

Amended Item #1 Per S.D.
1014194. S. Campbell

94 30001

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCIS JOHN CLEARY				2. DATE OF DEATH MONTH 9 DAY 30 YEAR 94				3. TIME OF DEATH 10:54P			
4. SOCIAL SECURITY NUMBER 77-046-07-3538		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/24/1917		8. BIRTHPLACE (State or Foreign Country) Connecticut			
9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Westminster				9c. COUNTY OF DEATH Carroll			
10a. STATE MD				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER Locust House, Apartment 209				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) welder		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Charles Cleary				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary McKenna							
19a. INFORMANT'S NAME (Type/Print) Loretta A. Cleary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Locust House, Apt. 209, Westminster, MD							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Branch Cemetery		DATE 10/4/94		20c. LOCATION — City or Town, State Westminster, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pritts-Switzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Now Such Cell Ca Lung Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Ca Prostate b. DUE TO (OR AS A CONSEQUENCE OF): Post Obstructive Pneumonia c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Sydney [Signature]						29c. LICENSE NUMBER 33502		29d. DATE SIGNED (Month, Day, Year) 10/1/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SEED - S. HOLTAN MD. Carol Co - Gen Hosp											
31. DATE FILED (Month, Day, Year) 001 04 1994						32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIA LEWIS CREW				2. DATE OF DEATH MONTH October DAY 6 YEAR 1994		3. TIME OF DEATH 2310 M	
4. SOCIAL SECURITY NUMBER 217 32 6159		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 20 1916	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. FACILITY NAME (If not institution, give street and number) Washington County Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Hagerstown, Md.				11. COUNTY OF DEATH Washington			
12. RESIDENCE OF DECEDENT				13. INSIDE CITY LIMITS?			
14a. STATE Maryland		14b. COUNTY Washington		14c. CITY, TOWN OR LOCATION Hagerstown		14d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
15. STREET AND NUMBER 412 North Jonathan Street				16. ZIP CODE 21740		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: Black	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 1 Year		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cosmetologist		24. KIND OF BUSINESS/INDUSTRY Beautician			
25. FATHER'S NAME (First, Middle, Last) Frank Crew				26. MOTHER'S NAME (First, Middle, Maiden Surname) Janey Rebecca Lewis			
27. INFORMANT'S NAME (Type/Print) Lenora Barbara Crew				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 N. Jonathan St. Hagerstown, MD. 21740			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven		31. DATE Hagerstown, MD.		32. LOCATION — City or Town, State	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas E. Watts				34. NAME AND ADDRESS OF FACILITY Watson Funeral Home 24 W. Bethel St. Hagerstown, MD. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease. DUE TO (OR AS A CONSEQUENCE OF): b. Insulin Dependent Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. HYPER TENSION DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Renal Insufficiency Approximately Interval Between Onset and Death: 3 years 2 years 10 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
35. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		38. DATE OF INJURY (Month, Day, Year) NA		39. TIME OF INJURY NA		40. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA		42. DESCRIBE HOW INJURY OCCURRED NA					
43. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA		44. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Harvey J. Kap.				29c. LICENSE NUMBER D28365		29d. DATE SIGNED (Month, Day, Year) 10/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILL STREET HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE John S. Benson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30003

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marguerite Ruth Charlton				2. DATE OF DEATH MONTH DAY YEAR October 07, 1994		3. TIME OF DEATH 2:20 A M	
4. SOCIAL SECURITY NUMBER 214-09-4076		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 28, 1909	
9a. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center				9b. CITY, TOWN OR LOCATION OF DEATH Williamsport		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Williamsport	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 16505 Virginia Avenue Cottage 42				10f. ZIP CODE 21795		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner-Operator		16b. KIND OF BUSINESS/INDUSTRY Trucking			
17. FATHER'S NAME (First, Middle, Last) E. Funk Bloyer				18. MOTHER'S NAME (First, Middle, Maiden Surname) M. Maude Sprecher			
19a. INFORMANT'S NAME (Type/Print) Charles Angle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22005 Ottawa Drive Smithsburg, Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 10-10-94		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Breast Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Lip Sarcoma</i> <i>Hypertension</i> <i>Peripheral vascular disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martha A. Riggle MD</i>				29c. LICENSE NUMBER D388968		29d. DATE SIGNED (Month, Day, Year) 10/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTHA A. RIGGLE 1110 Medical Campus Rd. Hagerstown, MD 21742							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30004

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert John Connolly				2. DATE OF DEATH MONTH DAY YEAR September 16, 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 071-24-0176		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/20/30		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 630 Brenda Lane				9b. CITY, TOWN OR LOCATION OF DEATH Aberdeen				9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 630 Brenda Lane				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) James J. Connolly				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Follick					
19a. INFORMANT'S NAME (Type/Print) Mrs. Renee B. Connolly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Brenda Lane Aberdeen, Maryland 21001					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 9/20		20c. LOCATION — City or Town, State Aberdeen, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kirsten Arny Unglesbee				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic soft tissue sarcoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER D and S Pittman MD - attending		29c. LICENSE NUMBER D17207		29d. DATE SIGNED (Month, Day, Year) Sept 22, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE John Anderson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30005

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Katie Mae Cook				2. DATE OF DEATH MONTH DAY YEAR September 27, 1994		3. TIME OF DEATH 5:00 p.m.	
4. SOCIAL SECURITY NUMBER 152-12-8743		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 2, 1908	
8. BIRTHPLACE (State or Foreign Country) Waynesboro, Ga.				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Virginia		10b. COUNTY Accomack	
10c. CITY, TOWN OR LOCATION Assawoman Virginia				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 51	
10f. ZIP CODE 23302				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7grade College (1-4 or 5+) College				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		15b. KIND OF BUSINESS/INDUSTRY Farm work	
17. FATHER'S NAME (First, Middle, Last) Henry Geilmore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Unk.			
19a. INFORMANT'S NAME (Type/Print) Mattie Robbins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 51 Assawoman Va. 2282			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Faith Cemetery		20c. LOCATION — City or Town, State Withams, Va. 23488	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Savage Funeral Home P.O. Box 46 3812 Davis Rd. New Church, Va. 23415			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W R Schmitz MD</i>				29c. LICENSE NUMBER 17596		29d. DATE SIGNED (Month, Day, Year) 9-27-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W R Schmitz 300 N Duval Hwy, LAUREL DE 19956							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94-5423-031
B.K.S

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADRIAN EDWARD CLIPPER		2. DATE OF DEATH SEPT. 19 94		3. TIME OF DEATH 1624 P M	
4. SOCIAL SECURITY NUMBER 218-30-3848		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Mar. 7, 1930		8. BIRTHPLACE (State or Foreign Country) Maryland		9. COUNTY OF DEATH MONTGOMERY	
10. FACILITY NAME (If not institution, give street and number) 12051 ROCKVILLE PIKE		11. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. STATE 10e. STATE		14. COUNTY 10b. COUNTY		15. CITY, TOWN OR LOCATION Washington, DC	
16. STREET AND NUMBER 1706 T Street, NW		17. ZIP CODE 20009		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
22. RACE — American Indian, Black, White, etc. Specify: Black		23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security Guard	
25. KIND OF BUSINESS/INDUSTRY Government		26. FATHER'S NAME (First, Middle, Last) Bozie Clipper		27. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Watson	
28. INFORMANT'S NAME (Type/Print) Edith Stewart (Sister)		29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9511 Stewarttown Rd., Gaithersburg, MD 20879		30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cem. 9/24		32. LOCATION — City or Town, State Silver Spring, MD		33. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George L. Snowden</i>	
34. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		36. APPROXIMATE Interval Between Onset and Death	
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>Inspection</i>		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>		41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY	
43. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		44. 28a. DATE OF INJURY (Month, Day, Year)		45. 28b. TIME OF INJURY M	
46. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		47. 28d. DESCRIBE HOW INJURY OCCURRED		48. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
49. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		49a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		49b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>	
49c. LICENSE NUMBER O.C.M.E		49d. DATE SIGNED (Month, Day, Year) SEPT. 20, 1994		50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201	
51. DATE FILED (Month, Day, Year) SEP 22 1994		52. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30007

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOIS CREADICK				2. DATE OF DEATH MONTH SEPTEMBER DAY 22 YEAR 1994				3. TIME OF DEATH 5:05 PM M	
4. SOCIAL SECURITY NUMBER 120-30-8193		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) OCT. 15, 1938				8. BIRTHPLACE (State or Foreign Country) NEW YORK					
9a. FACILITY NAME (If not institution, give street and number) 53 TIVOLI LAKE COURT				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 53 TIVOLI LAKE COURT				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLINICAL RESEARCH				16b. KIND OF BUSINESS/INDUSTRY MEDICAL			
17. FATHER'S NAME (First, Middle, Last) J. EUGENE CHALFIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADELE TEITELBAUM					
19a. INFORMANT'S NAME (Type/Print) LISA D. CREADICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20283 BEECHWOOD TERRACE #302-ASHBURN, VA. 22011					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) MT. COMFORT CREMATORY		DATE 9/26		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sandy M. J...</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. METASTATIC ADENOCARCINOMA OF UNKNOWN PRIMARY						Approximate Interval Between Onset and Death 2 1/2 MOS.	
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):							
		c. DUE TO (OR AS A CONSEQUENCE OF):							
		d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P KIDNEY TRANSPLANT 8/91									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Louis Kozloff</i>				29c. LICENSE NUMBER D23190		29d. DATE SIGNED (Month, Day, Year) 9/22/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LOUIS KOZLOFF, M.D. - 8218 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814									
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30008

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHLEEN CALLAGHAN				2. DATE OF DEATH MONTH DAY YEAR SEPT. 25, 1994		3. TIME OF DEATH 4:15 A M	
4. SOCIAL SECURITY NUMBER 217.04.1708		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 12 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1982	
9a. FACILITY NAME (If not institution, give street and number) MT. WASHINGTON PED. HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION POTOMAC		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8407 HARKER DRIVE				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NONE		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) KEVIN CALLAGHAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LINDA KIEFFER			
19a. INFORMANT'S NAME (Type/Print) LINDA BALDWIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8407 HARKER DR. POTOMAC, MD. 20854			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT		DATE 9/26		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph M. Peters</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS 5130 WISCONSIN AVE. N.W. WASHINGTON D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. SEVERE BILATERAL PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. NEURODEGENERATIVE DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eileen Talusan</i>				29c. LICENSE NUMBER D41252		29d. DATE SIGNED (Month, Day, Year) SEPT. 25, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EILEEN TALUSAN, M.D. 3001 S. HANOVER ST. BALTIMORE, MD. 21230							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 5 and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30009

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wallace W. Culver				2. DATE OF DEATH MONTH SEPT DAY 22 YEAR 1994		3. TIME OF DEATH 0512 A M	
4. SOCIAL SECURITY NUMBER 497-20-4160		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 31, 1910	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD.				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION POTOMAC	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 9504 WOODINGTON DR.			
10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROFESSOR		16b. KIND OF BUSINESS/INDUSTRY MONTGOMERY COLLEGE	
17. FATHER'S NAME (First, Middle, Last) ORRIS TRUMAN CULVER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET CATHERINE WHITE			
19a. INFORMANT'S NAME (Type/Print) LIANE M. CULVER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		DATE 9/22		20c. LOCATION — City or Town, State RIVERDALE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. W. Chambers</i>				22. NAME AND ADDRESS OF FACILITY MO0091 W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Severe Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 14-15 to 14-16 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Grobleman, MD</i>				29c. LICENSE NUMBER 1002404		29d. DATE SIGNED (Month, Day, Year) 9/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ACBERT H. GROBLEMAN, 1106 SPRING ST. SILVER SPRING, MD 20910							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

541

94 30010

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Winston Copeland</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Sept 25 94</i>				3. TIME OF DEATH HOURS MINUTES AM/PM <i>6 05 A</i>			
4. SOCIAL SECURITY NUMBER <i>089-26-2488</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 4, 1907</i>		8. BIRTHPLACE (State or Foreign Country) <i>Missouri</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Wilson Health Care</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Gaithersburg</i>				9c. COUNTY OF DEATH <i>Montgomery</i>			
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>				10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>301 Russell Avenue</i>				10f. ZIP CODE <i>20877</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Foreign Service Officer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Government</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Logan Copeland</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Cora Lula Burks</i>							
19a. INFORMANT'S NAME (Type/Print) <i>J. Reid Copeland</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Rt. 1 Box 522, Purcellville, Virginia 22132</i>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Montgomery Crematorium, Inc. 9/29/94</i>				20c. LOCATION — City or Town, State <i>Bethesda, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randy Famb</i> M00198				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>COPD</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death <i>gla</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Reid Copeland</i>				29c. LICENSE NUMBER <i>020518</i>				29d. DATE SIGNED (Month, Day, Year) <i>9/29/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. Reid Copeland 9410 011d Georgetown RD Bethesda MD 20814</i>											
31. DATE FILED (Month, Day, Year) <i>SEP 30 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5401-510

blh

94 30011

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wille Crawford			2. DATE OF DEATH MONTH DAY YEAR Sept. 19 1994		3. TIME OF DEATH 0145 M
4. SOCIAL SECURITY NUMBER 218-12-9954	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	8. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5 13 1919
9a. FACILITY NAME (If not institution, give street and number) Shock Trauma Center			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8. BIRTHPLACE (State or Foreign Country) MARYLAND
10a. STATE MARYLAND			10b. COUNTY ANNE ARUNDEL		9c. COUNTY OF DEATH
10c. CITY, TOWN OR LOCATION ANNAPOLIS			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 215 BOWIE AVENUE			10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify	
14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TAXI CAB DRIVER		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last) JIMMY CLAGETT			18. MOTHER'S NAME (First, Middle, Maiden Surname) ESSIE CRAWFORD		
19a. INFORMANT'S NAME (Type/Print) VEOLA CRAWFORD			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 BOWIE AVE. ANNAPOLIS, MD. 21401		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 9/26/94		20c. LOCATION — City or Town, State ANNAPOLIS, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry D. Reese</i>			22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Left Arm and Abdomen DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sulfide 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Sept. 18 1994		28b. TIME OF INJURY 2110 M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Shot by police			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) at home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 215 Bowie Ave. - Annapolis			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>			29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Sept. 19 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) SEP 27 1994		32. REGISTRAR'S SIGNATURE <i>John A. [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30012

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Henry Campbell				2. DATE OF DEATH MONTH September DAY 23 YEAR 1994		3. TIME OF DEATH 9:05A M	
4. SOCIAL SECURITY NUMBER 218-01-3536		5. SEX XX M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 23, 1912	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 35 St. Mark's Church Road				10f. ZIP CODE 21903		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Four Years		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Foreman		15b. KIND OF BUSINESS/INDUSTRY Aberdeen Proving Ground Aberdeen, Maryland			
17. FATHER'S NAME (First, Middle, Last) George Ralph Campbell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Zimmerman			
19a. INFORMANT'S NAME (Type/Print) George R. Campbell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 St. Mark's Church Rd., Perryville, Maryland 21903			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Erin Cemetery		20c. DATE 9/26/94		20d. LOCATION — City or Town, State Havre de Grace, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert Patterson, Jr.				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIO-PULMONARY ARREST 2° DUE TO (OR AS A CONSEQUENCE OF): DIC & MASSIVE SYSTEMIC HEMORRHAGE 2° DUE TO (OR AS A CONSEQUENCE OF): ENDOCARDITIS, AORTIC VALVE CAUSING DUE TO (OR AS A CONSEQUENCE OF): THROMBO-EMBOLISM & SPLEEN & BRAIN aggravating PRE-EXISTING OCCIPITAL & CEREBRAL INFARCT Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Antonio H. Calon, M.D.				29c. LICENSE NUMBER D20655		29d. DATE SIGNED (Month, Day, Year) 9/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTONIO H. CALON, M.D. 611 South Union Avenue Havre de Grace, Maryland 21078							
31. DATE FILED (Month, Day, Year) SEP 26 '94		32. REGISTRAR'S SIGNATURE Johia Davidson-Rendell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30013

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA MARIE CRAMER				2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1994		3. TIME OF DEATH 12:45AM M	
4. SOCIAL SECURITY NUMBER 820-00-1483		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 6, 1899	
8. BIRTHPLACE (State or Foreign Country) Germany		9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA		9c. COUNTY OF DEATH CHARLES	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION La Plata		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 225 at Ripley Park				10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY At Home			
17. FATHER'S NAME (First, Middle, Last) Phillip Salzman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kathrine Steinhauser			
19a. INFORMANT'S NAME (Type/Print) Phyllis Juhle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1425, Little River, S.C. 29566			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens 10/1/94, Waldorf, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE J C Echols		M-00174		22. NAME AND ADDRESS OF FACILITY AREHART-ECOLS FUNERAL HOME P.O. BOX 567, La Plata, Md. 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acute left Ventricular Failure Int. Interstitial lung Disease Bronchitis & emphysema							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Henry L. Burke M.D.				29c. LICENSE NUMBER D-01009		29d. DATE SIGNED (Month, Day, Year) 9-29-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENRY L. BURKE M.D. 115-A LA GRANGE AVENUE P.O. BOX 591 LA PLATA MD. 20646							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE John Davidson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30014

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) W. Woodrow Cullen				2. DATE OF DEATH MONTH 9 - DAY 28 - YEAR 94		3. TIME OF DEATH 11:20p AM	
4. SOCIAL SECURITY NUMBER 158-09-6548		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 29, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital			
9b. CITY, TOWN OR LOCATION OF DEATH Crisfield				9c. COUNTY OF DEATH Somerset			
10a. STATE Maryland				10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 26524 Dulaney Avenue			
10f. ZIP CODE 21817				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II- U.S. Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate College (14 or 5+) - - -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Forklift Operator		16b. KIND OF BUSINESS/INDUSTRY Armco Steel Corp.	
17. FATHER'S NAME (First, Middle, Last) Wade H. Cullen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ola Marie Garrison			
19a. INFORMANT'S NAME (Type/Print) Woodrow W. Cullen, Jr. (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2755 Lloyd Webb Rd. - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-10/1/94		20c. LOCATION — City or Town, State Crisfield, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.	
22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. 21817		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Generalized Atherosclerosis						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER James A. Sterling, MD 29c. LICENSE NUMBER D10814 29d. DATE SIGNED (Month, Day, Year) 9/28/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Dr. James A. Sterling, Main St., Crisfield, Md. 21817							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(R)

Wm. B. Smith

Acute Myocardial Infarction

1894

the original of the case

OCT 02 1894

94 30015

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK VINCENT CURTIS				2. DATE OF DEATH MONTH 10 DAY 4 YEAR 94		3. TIME OF DEATH 1240 P.M.	
4. SOCIAL SECURITY NUMBER 159-14-3259		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 3, 1919	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
9b. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Mount Airy		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12623 Molesworth Drive				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? American	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Transportation Officer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Frank Eugene Curtis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annette Gow			
19a. INFORMANT'S NAME (Type/Print) Virginia J. Curtis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12623 Molesworth Drive, Mount Airy, Md. 21771			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Mem. Gardens 10/7 Frederick, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. Williams		22. NAME AND ADDRESS OF FACILITY Olin J. Molesworth, P.A., Funeral Home 26401 Ridge Rd., Damascus, Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dilated Cardiomyopathy Severe Mitral Regurgitation Congestive Heart Failure Fluid Chest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Bladder Cancer Motor Vehicle Accident DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder Cancer Motor Vehicle Accident							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10/3/94		28b. TIME OF INJURY 0830 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Driver of Auto Struck fixed object		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Bartholomew Road Old Mt L Pike			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER H. Neal Reynolds				29c. LICENSE NUMBER D 2763		29d. DATE SIGNED (Month, Day, Year) 10/4/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H.N. Reynolds MD, Dept. Critical Care, 22 S. Greene St., Baltimore, Md							
31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE Johanna Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30016

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Ann Dwyer				2. DATE OF DEATH MONTH DAY YEAR Sept. 28, 1994		3. TIME OF DEATH 12:30 A. M	
4. SOCIAL SECURITY NUMBER 446-07-1118		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 16, 1900	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Bethesda Rehabilitation Center		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE none			
10b. COUNTY none				10c. CITY, TOWN OR LOCATION Washington, D.C.			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 5863 Chevy Chase Parkway, N.W.			
10f. ZIP CODE 20015				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Orville Desmond Hennage				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mayme Bridget Flanagan			
19a. INFORMANT'S NAME (Type/Print) Michael J. Dwyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 20th St., N.W. #202, Wash., D.C. 20009			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 9-30-94		20c. LOCATION — City or Town, State Silver Spring, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John F. DeVal</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RHEUMATIC HEART DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 70 years.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin G. Nealon, M.D.</i>				29c. LICENSE NUMBER D04179		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5530 Wisconsin Avenue, Suite #925, Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30017

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Michael Donohue				2. DATE OF DEATH MONTH DAY YEAR September 27 94		3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 187-22-1506		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 23, 1930	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH LaPlata	
9c. COUNTY OF DEATH Charles				10a. STATE Maryland		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION Waldorf				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1020 Stoddert Avenue	
10f. ZIP CODE 20602				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Home Construction	
17. FATHER'S NAME (First, Middle, Last) John P. Donohue				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sabina V. Mc Kenna			
19a. INFORMANT'S NAME (Type/Print) Dorothy Eileen Donohue				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Stoddert Avenue, Waldorf, Maryland 20602			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Resurrection Cemetery 10-01-94		20c. LOCATION — City or Town, State Clinton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark G. Brohawn M00053				22. NAME AND ADDRESS OF FACILITY THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MD. 20604			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarct b. atherosclerotic cardiovascular disease c. diabetes d. hypertension Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Timothy R. Pace				29c. LICENSE NUMBER D-22574		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy R. Pace MD P.O. Box 249 Waldorf, MD 20604							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30018

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose Marie Davis				2. DATE OF DEATH MONTH DAY YEAR Sept. 29, 1994		3. TIME OF DEATH 4:45 p M	
4. SOCIAL SECURITY NUMBER 212-24-4300		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-2-1929	
9a. FACILITY NAME (If not institution, give street and number) Franklin Woods Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3618 Raven Wood Ave.				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Ernest E. Stinnett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jessie P. Ratcliff Stinnett			
19a. INFORMANT'S NAME (Type/Print) Katheline Hamilton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Raven Wood Ave. Baltimore, MD 21213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Old Durham Cem. 10/3/1994		20c. LOCATION — City or Town, State Ironsides, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Echols M00945				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. LaPlata, MD 20646			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: months b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Susan Levy		29c. LICENSE NUMBER D33943		29d. DATE SIGNED (Month, Day, Year) 9/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Susan Levy, Franklin Square Hosp. 9000 Franklin Square Dr. Baltimore, Md 21237							
31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30019

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Clarence Daugherty				2. DATE OF DEATH MONTH 9 DAY 30 YEAR 1994				3. TIME OF DEATH 3:00 P M	
4. SOCIAL SECURITY NUMBER 214-14-3223		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1917				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Residence: 630 Aiken Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Perryville				9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Cecil				10c. CITY, TOWN OR LOCATION Perryville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 630 Aiken Avenue				10f. ZIP CODE 21903	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943 - 1944	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Eleven Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk (Commissary)				16b. KIND OF BUSINESS/INDUSTRY Aberdeen Proving Ground Aberdeen, Maryland	
17. FATHER'S NAME (First, Middle, Last) Earl Daugherty				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Johnson					
19a. INFORMANT'S NAME (Type/Print) M. Jean Daugherty				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Aiken Avenue, Perryville, Maryland 21903					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Hopewell Cemetery 10/4/94				20c. LOCATION - City or Town, State Port Deposit, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas M. Patterson, Sr.				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 15 MON					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CONGESTIVE HEART FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER John P. Edwards				29c. LICENSE NUMBER 21047	
29d. DATE SIGNED (Month, Day, Year) 9/30/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John P. Edwards 212 BEL AIR RD PERRYVILLE, MD 21903					
31. DATE FILED (Month, Day, Year) OCT-04 '94				32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED		MILDRED (nm) DARLINGTON DARLINGTON		2. DATE OF DEATH MONTH DAY YEAR 09 - 23 - 94		3. TIME OF DEATH 5:27 PM	
4. SOCIAL SECURITY NUMBER 221-22-0880		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 30, 1909	
9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON		9c. COUNTY OF DEATH DELEWARE			
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2116 Ruffs Mill Road				10f. ZIP CODE 21015		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/ Beautician		16b. KIND OF BUSINESS/INDUSTRY Cosmetology/ Hairdressing			
17. FATHER'S NAME (First, Middle, Last) Frank (nm) Lenkiewicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vincentina (unknown)			
19a. INFORMANT'S NAME (Type/Print) Barbara W. Kulinski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2116 Ruffs Mill Road, Bel Air, Md. 21015			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cathedral Cemetery		DATE 9/27/94		20c. LOCATION — City or Town, State Wilmington, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Hip Fracture c. DUE TO (OR AS A CONSEQUENCE OF): Osteoporosis TRAUMA INDUCED BY A FALL d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 12 hrs 6 days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Dr. Colfer		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D 30653		29d. DATE SIGNED (Month, Day, Year) 9-23-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Roger E. Schneider — 2112 Bel Air Rd., Fallston, MD 21047							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020


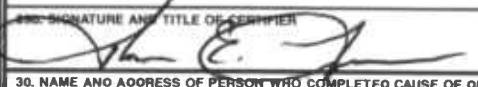
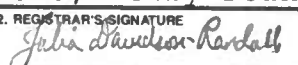
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

94 30021

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT L DAVIS						2. DATE OF DEATH MONTH 9 DAY 28 YEAR 94		3. TIME OF DEATH 8:28P M	
4. SOCIAL SECURITY NUMBER 215121129		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6 19 22		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Perry Point VA Medical Center						9b. CITY, TOWN OR LOCATION OF DEATH Perry Point, Md.		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 505 Congress Avenue				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk		16b. KIND OF BUSINESS/INDUSTRY Sporting Goods/Retail			
17. FATHER'S NAME (First, Middle, Last) Bernard Davis						18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Hammond			
19a. INFORMANT'S NAME (Type/Print) Mr. Richard D. Marlin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 324, Buxton, NC 27920					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 10/4				20c. LOCATION — City or Town, State West Chester, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D32395		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas Finucan, M.D., Perry Point VA Medical Center									
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30022

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edwin V. Dove				2. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1994				3. TIME OF DEATH 9:00AM M					
4. SOCIAL SECURITY NUMBER 577-05-2644		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 25, 1908		8. BIRTHPLACE (State or Foreign Country) Washington, DC	
9a. FACILITY NAME (If not institution, give street and number) Carriage Hill -Bethesda						9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 4510 Gladwyne Drive						10f. ZIP CODE 20814				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Photoengraver				16b. KIND OF BUSINESS/INDUSTRY Government Printing Office					
17. FATHER'S NAME (First, Middle, Last) Ernest Wimsatt Dove						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Agnes Flannigan							
19a. INFORMANT'S NAME (Type/Print) W. Ella Dove						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Gladwyne Drive, Bethesda, Maryland 20814							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 9/27/94				20c. LOCATION — City or Town, State Suitland, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wanda E. Perry</i> M00803						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):												1-2 Hrs.	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST f. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):												10 yrs.	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____ DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul T. Noone</i>						28c. LICENSE NUMBER D07421				29d. DATE SIGNED (Month, Day, Year) Sept. 23, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul T. Noone, M.D. 50 W. Edmonston Drive, #207, Rockville, Maryland 20852													
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30023

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rudolph T. Danstedt				2. DATE OF DEATH MONTH DAY YEAR Sept. 26 94				3. TIME OF DEATH 12:15 P M					
4. SOCIAL SECURITY NUMBER 490-36-0466				5. SEX 1 X M 2 F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1904		8. BIRTHPLACE (State or Foreign Country) Massachusetts			
9a. FACILITY NAME (If not institution, give street and number) H. Wilson Health Care Ctr.						9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg			9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT													
10a. STATE Maryland			10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 F YES 2 X NO				
10e. STREET AND NUMBER 3121 Farnborough Court						10f. ZIP CODE 20906			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 F Never Married 2 F Married 3 X F Widowed 4 F Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 F YES 2 X NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 F YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive				16b. KIND OF BUSINESS/INDUSTRY Social Work					
17. FATHER'S NAME (First, Middle, Last) Theodore Danstedt						18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhelmina Carlson							
19a. INFORMANT'S NAME (Type/Print) Rudolph T. Danstedt						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4757 Chevy Chase Drive, #209, Chevy Chase, MD 20815							
20a. METHOD OF DISPOSITION 1 F Burial 2 X Cremation 3 F Removal from State 4 F Donation 6 F Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. September 27, 1994				20c. LOCATION — City or Town, State Bethesda, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael O. Kutto M00348						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction													
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. Arteriosclerotic cardiovascular disease													
c. yes.													
d. 4 hours													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 F YES 2 X NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 F YES 2 X NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 F YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 F Inpatient 2 F ER/Outpatient 3 F DOA OTHER: 4 X Nursing Home 5 F Residence 6 F Other (Specify)									
27. MANNER OF DEATH 1 X Natural 2 F Accident 3 F Suicide 4 F Homicide 5 F Pending Investigation 6 F Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 F YES 2 F NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) 2 F MEDICAL EXAMINER						29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29c. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29d. SIGNATURE AND TITLE OF CERTIFIER Steven Levinson M.D.							
29e. LICENSE NUMBER D18186						29f. DATE SIGNED (Month, Day, Year) 9/26/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Levinson, M.D., 301 Russell Ave., Gaithersburg, Maryland 20877													
31. DATE FILED (Month, Day, Year) SEP 28 1994						32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED RECORDS

Handwritten notes and signatures, including a large signature at the bottom right.

94 30024

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annie M. Duffin				2. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1994		3. TIME OF DEATH 11:30 p.m.	
4. SOCIAL SECURITY NUMBER 214-32-8353		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 31, 1932	
9a. FACILITY NAME (If not institution, give street and number) 3906 Jeffry Street				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3906 Jeffry Street				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Central Supply Tech.		16b. KIND OF BUSINESS/INDUSTRY Hospital			
17. FATHER'S NAME (First, Middle, Last) William M. Palmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Simms			
19a. INFORMANT'S NAME (Type/Print) Lorenzo E. Duffin (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 Jeffry St., Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Marks Cemetery		DATE 9/30		20c. LOCATION — City or Town, State Boys, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Miller MD</i>				29c. LICENSE NUMBER D33688		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth Miller MD 16111 Rouse Phoebe Dr. Olney, MD 2880							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Judith Davidson-Fordell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30025

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Lavana Dimarco			2. DATE OF DEATH MONTH DAY YEAR Sept. 27 1994		3. TIME OF DEATH 10:15 P M
4. SOCIAL SECURITY NUMBER 220-07-8736	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) 9/3/20	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford
RESIDENCE OF DECEDENT					
10a. STATE Maryland	10b. COUNTY Harford	10c. CITY, TOWN OR LOCATION Havre de Grace		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 415 N. Stokes Street			10f. ZIP CODE 21078	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Grocery Store	
17. FATHER'S NAME (First, Middle, Last) Morgan L. Cullum			18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Virginia Knellinger		
19a. INFORMANT'S NAME (Type/Print) Mr. Henry DiMarco			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 N. Stokes St., Havre de Grace, MD 21078		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Methodist Cemetery 9/30		20c. LOCATION — City or Town, State Churchville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kirsten Amy Unglesbee			22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Carcinoma Bladder					Approximate Interval Between Onset and Death 1 week
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis due to infection					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Irvin L. Wachsman M.D.			29c. LICENSE NUMBER D 11491	29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
31. DATE FILED (Month, Day, Year) SEP 29 1994		32. REGISTRAR'S SIGNATURE Irvin L. Wachsman M.D.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30026

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SONIA A. DORRELL				2. DATE OF DEATH MONTH 9 DAY 22 YEAR 94				3. TIME OF DEATH 0105 A	
4. SOCIAL SECURITY NUMBER 222-40-8129		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-11-63		8. BIRTHPLACE (State or Foreign Country) Delaware	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE Delaware		10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Seaford				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 111 Tull Dr.				10f. ZIP CODE 19973		10g. CITIZEN OF WHAT COUNTRY? U. S.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) James C. Dorrell Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jerdie K. Marine					
19a. INFORMANT'S NAME (Type/Print) James C. Dorrell Jr. - father				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Oak Rd; Seaford, De. 19973					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory 9/23/94			20c. LOCATION — City or Town, State Dover, De.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John A. Cranston				22. NAME AND ADDRESS OF FACILITY Cranston Funeral Home P O Box 967; Seaford, De. 19973					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. URINARY TRACT INFECTION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 DAYS									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MENINGOENCEPHALITIS WITH PARAPLEGIA OBESITY MULTIPLE DECUBITI								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Ronald P. Travis MD				29c. LICENSE NUMBER D36576		29d. DATE SIGNED (Month, Day, Year) 9/22/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RONALD P. TRAVIS MD 560 Riverdale drive Saline MD 21861									
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE Julia Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30027

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Dykes				2. DATE OF DEATH MONTH DAY YEAR 9/20/94		3. TIME OF DEATH 10:35 p.m.	
4. SOCIAL SECURITY NUMBER 213-12-5206		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 7, 1907	
9a. FACILITY NAME (If not Institution, give street and number) Deer's Head Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 200 Meadowlark Dr.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Auto repair			
17. FATHER'S NAME (First, Middle, Last) William Byrd Trader				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Priscilla Adkins			
19a. INFORMANT'S NAME (Type/Print) Ernest W. Dykes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 Mt. Hermon Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dykes Family Cemetery		DATE 9/23		20c. LOCATION — City or Town, State Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Arteriosclerotic Cardiovascular Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Alzheimer's Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) 9/24/94			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D16003		29d. DATE SIGNED (Month, Day, Year) 9/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) I. J. Hwang, M.D., Deer's Head Center, Salisbury, MD, 21801							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30028

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM DAVID DUPPINS				2. DATE OF DEATH MONTH 9 - DAY 27 - YEAR 94		3. TIME OF DEATH 19 10 7 P.M.	
4. SOCIAL SECURITY NUMBER 212-03-7798		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 19, 1906	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Union Bridge				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 5 Thomas St.	
10f. ZIP CODE 21791				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) bulldozer operator		16b. KIND OF BUSINESS/INDUSTRY cement co.	
17. FATHER'S NAME (First, Middle, Last) William Duppins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara Black			
19a. INFORMANT'S NAME (Type/Print) Preston O. Duppins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 401 Union Bridge, MD 21791			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oldfields Cemetery 9/30		20c. LOCATION — City or Town, State nr. Libertytown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Union Bridge, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CA Lung; post obstructive pneumonia, Atrial Fibrillation, congestive Heart Failure, Basaloid Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CA Aortic aneurysm, + no serology							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank H. MD</i>				29c. LICENSE NUMBER D38915		29d. DATE SIGNED (Month, Day, Year) 9/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRE 151 542 WORTH Rd Westminster							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>John Dawson Radall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30029

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth M. Duvall</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>03</i> YEAR <i>94</i>				3. TIME OF DEATH <i>12:05 PM</i>	
4. SOCIAL SECURITY NUMBER <i>218-38-8729</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) <i>12-08-1905</i>				8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Marlin Manor</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Pr. Anne, MD.</i>				9c. COUNTY OF DEATH <i>Somerset</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Somerset</i>		10c. CITY, TOWN OR LOCATION <i>Princess Anne</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11911 Crisfield Lane</i>				10f. ZIP CODE <i>21853</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Prince Georges County</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Howard Miles</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Josephine Howeth</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Mr. William H. Duvall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3110 Middlewood Rd, Midlothian, Virginia 23113</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Thomas Episcopal Cem. 10/5</i>		20c. LOCATION — City or Town, State <i>Croome, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Kim</i> M00295				22. NAME AND ADDRESS OF FACILITY <i>Hinman Funeral Home 11673 Somerset Ave, Pr. Anne, Md. 21853</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio Respiratory Failure</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Sepsis - gram negative</i>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Lymphocytic Leukemia</i> <i>Anemia</i> <i>Hypoalbuminemia</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M _____		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
27a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jesus Evangelista</i>				29c. LICENSE NUMBER <i>D28542</i>	
29d. DATE SIGNED (Month, Day, Year) <i>10/3/94</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jesus Evangelista MD., 324 Main Street, Crisfield, Md. 21817</i>					
31. DATE FILED (Month, Day, Year) <i>OCT 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NELLIE DALRYMPLE

94 30030

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NELLIE CREIGHTON DALRYMPLE				2. DATE OF DEATH MONTH DAY YEAR Sept. 26 1994				3. TIME OF DEATH 11:35 P M					
4. SOCIAL SECURITY NUMBER 214-07-7440		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) NOV. 16 1904		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & REHAB CENTER						9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.				9c. COUNTY OF DEATH WICOMICO			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER Route 50 & Civic Ave.						10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) sewing machine operator				16b. KIND OF BUSINESS/INDUSTRY garment manufacturing					
17. FATHER'S NAME (First, Middle, Last) Charles R. Creighton						18. MOTHER'S NAME (First, Middle, Maiden Surname) Matilda Adams							
19a. INFORMANT'S NAME (Type/Print) Mrs. Margaret Cannon						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Bonnie Brook Rd. Cambridge MD 21613							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Lawn Cemetery 9/29		DATE		20c. LOCATION — City or Town, State Cambridge Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth R. Thomas Jr.						22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Euthanasia</i>													
Due TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST f. <i>cardiac infarct</i>													
Due TO (OR AS A CONSEQUENCE OF):													
Due TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D-29349		29d. DATE SIGNED (Month, Day, Year) 9/27/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801													
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Johi Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DE HIGH SCHOOL

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94 30031

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bennett V. Dorsey Bennett Dorsey				2. DATE OF DEATH MONTH 9 DAY 28 YEAR 94		3. TIME OF DEATH 1010 P M	
4. SOCIAL SECURITY NUMBER 213-22-8620		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-11-25	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) Dorchester Gen. Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge	
9c. COUNTY OF DEATH Dorchester				10a. STATE MD		10b. COUNTY Dorchester	
10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 617 Cross Street	
10f. ZIP CODE 21613				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade - 7 College (14 or 5+) Machine Operator				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William Dorsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kate Pritchett			
19a. INFORMANT'S NAME (Type/Print) Leon Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Cross St. Cambridge, Md. 21613			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery 10/5 Cambridge, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Janette C. Henry				22. NAME AND ADDRESS OF FACILITY Henry Funeral Home 510 Washington St. Cambridge, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Perforated Viscous Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Perforated Viscous DUE TO (OR AS A CONSEQUENCE OF): Abdominal Carcinomatosis b. Abdominal Carcinomatosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 4 days 1 year							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Fadden MD				29c. LICENSE NUMBER 026388		29d. DATE SIGNED (Month, Day, Year) 9-29-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Fadden MD 302 Collins Hflock md 21643							
31. DATE FILED (Month, Day, Year) SEP 30 1994				REGISTRAR'S SIGNATURE John A. Hadden			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician until the funeral director, page 5 should be detached for use as the burial-transit certificate. The law requires that the death certificate be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate, or removal.

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) LYNNE W. Dill				2. DATE OF DEATH MONTH DAY YEAR Sept. 27 1994				3. TIME OF DEATH 4:50 P M					
4. SOCIAL SECURITY NUMBER 155-28-3396				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 11 '33		8. BIRTHPLACE (State or Foreign Country) NJ			
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Poolesville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 18125 Cattail Rd.						10f. ZIP CODE 20837		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vet. assistance				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) William Whitehead						18. MOTHER'S NAME (First, Middle, Maiden Surname) Marvel Souders							
19a. INFORMANT'S NAME (Type/Print) Leonard C. Dill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18125 Cattail Rd. Poolesville, Md. 20837									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 9/29 Smithsburg, Md.				DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace Helt				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Box 86 Barnesville, Md. 20838									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. RADIATION ENCEPHALOMALACIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC SMALL CELL CANCER										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Chenaw MD						29c. LICENSE NUMBER D 33224		29d. DATE SIGNED (Month, Day, Year) Sept 28, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. TRENAN MD SDW Edmonston Dr #506 Rockville MD 20852													
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall									

94 30033

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Betty June Estevez				2. DATE OF DEATH MONTH DAY YEAR September 30 94		3. TIME OF DEATH 8:50 A M	
4. SOCIAL SECURITY NUMBER 212-24-4060		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1927	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH LaPlata	
9c. COUNTY OF DEATH Charles				10a. STATE Maryland		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION La Plata				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 9 Somerset Street, P.O. Box 264	
10f. ZIP CODE 20646				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Clerk, Retired		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service	
17. FATHER'S NAME (First, Middle, Last) Hudson Albert McNeil				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nanny Lee Osborn			
19a. INFORMANT'S NAME (Type/Print) James Estevez				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 264, La Plata, Md. 20646			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart Cemetery 10/4/94 La Plata, Md.		20c. LOCATION - City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>G. C. Echols</i> M-00174				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME P.O. BOX 567, La Plata, Md. 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmonary arrest b. Acute Myocardial Infarct Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, Hypertension.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Smith (Attending Physician)</i>		29c. LICENSE NUMBER D-12587	
29d. DATE SIGNED (Month, Day, Year) 9-30-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Girija Rath MD 7C Post Office Road Cenna Center Waldorf, MD. 20602		31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30034

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine Elizabeth Ernst				2. DATE OF DEATH MONTH DAY YEAR 09 28 94		3. TIME OF DEATH 11:05 P M	
4. SOCIAL SECURITY NUMBER 213-18-8678		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/21/14	
9a. FACILITY NAME (If not institution, give street and number) Western Maryland Center				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown, MD 21742-3194		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11 W. Baltimore Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) salesperson		16b. KIND OF BUSINESS/INDUSTRY retail grocery store	
17. FATHER'S NAME (First, Middle, Last) John Aumen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Anderson			
19a. INFORMANT'S NAME (Type/Print) John G. Ernst, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10433 Sharpsburg Pike, Hagerstown, Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 10-1-94		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Minnich</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Peritonitis - Sepsis</i>					
		b. <i>ESRD on peritoneal dialysis (Cardio Renal Syndrome)</i>					
		c. <i>Hypertension</i>					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease; Cardiac pacemaker Inter trochanteric fracture of hip & internal fixation Peripheral vascular disease Hypertension; Pancreatitis; Diverticulosis</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 3-11-1994		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Due to Fall		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Western Maryland Center			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1500 Pennsylvania Ave Hagerstown MD-21742					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Aumen</i> Medical Officer				29c. LICENSE NUMBER D34165		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMED S. ALI 1500 Pennsylvania Ave Hagerstown, MD. 21742							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE <i>John Aumen</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30035

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LEE Estrada				2. DATE OF DEATH MONTH DAY YEAR Sept. 24 1994 2048 M				3. TIME OF DEATH			
4. SOCIAL SECURITY NUMBER 217-34-6302		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 26, 1937		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION DELMAR				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 30144 OAKHAVEN AVENUE				10f. ZIP CODE 21875		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) —				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY —					
17. FATHER'S NAME (First, Middle, Last) LEROY JOHNSON, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA BRIDGETT WEILER							
19a. INFORMANT'S NAME (Type/Print) ANTONIO G. ESTRADA, SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30144 OAKHAVEN AVENUE, DELMAR, MD 21875							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SALISBURY CREMATORY		DATE 9/28		20c. LOCATION — City or Town, State SALISBURY, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leonard D. Zeller</i>				22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, OLD OCEAN CITY ROAD P.O. BOX 3171, SALISBURY, MD 21802							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Atherosclerotic cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen Paulos</i>		29c. LICENSE NUMBER D41721		29d. DATE SIGNED (Month, Day, Year) 9-25-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Paulos 560 Riverside Dr. Salisbury, Md 21801											
31. DATE FILED (Month, Day, Year) SEP 30 1994		32. REGISTRAR'S SIGNATURE <i>John A. Swanson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CONFIDENTIAL

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/01 BY 60322

(R)

94 30036

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond G. FREMEAU				2. DATE OF DEATH MONTH 9 DAY 23 YEAR 94		3. TIME OF DEATH 12:19 P.M.	
4. SOCIAL SECURITY NUMBER 015-07-6452		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-30-09	
9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24 HARBOR MIST				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESSMAN		16b. KIND OF BUSINESS/INDUSTRY GOVT. PRtg. OFFICE			
17. FATHER'S NAME (First, Middle, Last) JOHN B. FREMEAU				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE LOUISE BRODEUR			
19a. INFORMANT'S NAME (Type/Print) JACK FREMEAU				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 949 CARRIAGE HILL RD. VA. BEACH, VA., 23452			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF THE PINES 9/27		20c. LOCATION — City or Town, State BERLIN, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DISSECTING THORACIC AORTIC Aneurysm DUE TO (OR AS A CONSEQUENCE OF): b. HTN DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER H43617		29d. DATE SIGNED (Month, Day, Year) 9/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCOTT SWEENEY DO 314 FRANKLIN AVE BERLIN MD 21811							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

RECEIVED

2

RECEIVED

Amended # 17, # 19b # 20b 9/28/94 MRT Montgomery County
94 30037

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Sylvia B Feldman</i>				2. DATE OF DEATH MONTH DAY YEAR 09 26 1994		3. TIME OF DEATH 3:30P M					
4. SOCIAL SECURITY NUMBER 082-05-8096		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-26-1901		8. BIRTHPLACE (State or Foreign Country) BROOKLYN NY			
9a. FACILITY NAME (If not institution, give street and number) greenbelt nursing center				9b. CITY, TOWN OR LOCATION OF DEATH GREENBELT				9c. COUNTY OF DEATH prince george			
10a. STATE FLORIDA		10b. COUNTY palm beach		10c. CITY, TOWN OR LOCATION WEST PALM BEACH				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER CENTURY VILLAGE - WELLINGTON C112				10f. ZIP CODE 33417		10g. CITIZEN OF WHAT COUNTRY? united States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME							
17. FATHER'S NAME (First, Middle, Last) MAX BLOCH				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA KAVALERCHIK							
19a. INFORMANT'S NAME (Type/Print) MARJORIE BEIGMANN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 LAKESIDE DRIVE GREENBELT, MARYLAND 20770							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. LEBANON CEMETERY 9/29		20c. LOCATION — City or Town, State BROOKLYN NEW YORK							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A Stone</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death 1 day 3 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>congestive heart failure</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>D Granite MD</i>		29c. LICENSE NUMBER D17572		29d. DATE SIGNED (Month, Day, Year) 9/26/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D Granite MD 115 enterway Greenbelt, MD 20770											
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30038

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARILYN FRIEDEL				2. DATE OF DEATH MONTH SEPTEMBER DAY 26 , YEAR 1994				3. TIME OF DEATH 3:55PM M	
4. SOCIAL SECURITY NUMBER 218-52-8445		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) OCT. 17, 1924	
9a. FACILITY NAME (If not institution, give street and number) 3530 TWIN BRANCHES DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3530 TWIN BRANCHES DRIVE				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE			16b. KIND OF BUSINESS/INDUSTRY MEDICAL			
17. FATHER'S NAME (First, Middle, Last) MILTON NEUMANN				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE ROSENBAUM					
19a. INFORMANT'S NAME (Type/Print) KAREN L. FRIEDEL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15313 MANOR VILLAGE LANE-ROCKVILLE, MD. 20853					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or funeral home) JUDEAN MEMORIAL GARDENS		DATE 9/29		20c. LOCATION — City or Town, State OLNEY, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>4 1/2 yr</i> <i>1 yr</i>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hyperlipidemia, Bacterial Disease</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D10690		29d. DATE SIGNED (Month, Day, Year) 9/27/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDGAR H. LEVIN, M.D. - 9801 GEORGIA AVENUE #341 - SILVER SPRING, MD. 20902									
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 9c, 106, 9/30/94, JW, Montgomery Co. 94 30039

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EUGENE T. FRECHETTE				2. DATE OF DEATH MONTH DAY YEAR SEPT. 26, 1994		3. TIME OF DEATH 1:05 P	
4. SOCIAL SECURITY NUMBER 047 22 4461		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 23, 1930	
8. BIRTHPLACE (State or Foreign Country) CONN				9a. FACILITY NAME (If not institution, give street and number) 717 DEVONSHIRE RD.		9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK	
9c. COUNTY OF DEATH Prince Georges				10a. STATE MD		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION TAKOMA PARK				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 717 DEVONSHIRE RD.	
10f. ZIP CODE 20912				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREN WAR				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TWO			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) QUALITY CONTROL				16b. KIND OF BUSINESS/INDUSTRY ELECTONICS			
17. FATHER'S NAME (First, Middle, Last) ARTHUR FRECHETTE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET HOGAN			
19a. INFORMANT'S NAME (Type/Print) ARTHUR FRECHETTE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 289 TAYLOR AVE. CHESHIRE, CONN. 06410			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) GEORGE WASHINGTON CEMETERY 9/30/94 ADELPHI, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME INC 254 CARROLL ST NW WASHINGTON, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gastrointestinal Bleeding Esophageal Varices Cirrhosis of liver Coronary Artery Disease 1 year							
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year) SEP 26 1994							
28b. TIME OF INJURY M							
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD							
29c. LICENSE NUMBER D-33482							
29d. DATE SIGNED (Month, Day, Year) 9/28/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sajeev Anand, M.D. 7227 HANOVER PARKWAY, SUITE B, GREENBELT, MD.							
31. DATE FILED (Month, Day, Year) SEP 29 1994							
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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GENERAL

RECEIVED

Amended #1, 9/30/94, JW, Montgomery Co

94 30046

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Miriam Freed</i>			2. DATE OF DEATH MONTH <i>9</i> DAY <i>27</i> YEAR <i>94</i>		3. TIME OF DEATH <i>7 PM</i>
4. SOCIAL SECURITY NUMBER <i>217-09-2076</i>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>87</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH MONTH <i>Aug.</i> DAY <i>31</i> YEAR <i>1907</i>
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION BETHESDA		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7420 WESTLAKE TERRACE #1405			10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>12</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) HERMAN MITTMAN			18. MOTHER'S NAME (First, Middle, Maiden Surname) LEAH FELDMAN		
19a. INFORMANT'S NAME (Type/Print) HAROLD FREED (SON)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 CALAVERA PLACE - FULLERTON, CA. 92633		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremation or other place) ARLINGTON CEMETERY		20c. LOCATION — City or Town, State 9/29 BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry M. J...</i>			22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ca...</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <i>1 yr. Pleuro...</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death <i>1 Day</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <i>M</i>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			29c. LICENSE NUMBER <i>D10690</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/27/94</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>EDGAR H. LEVIN, 1881 GERRARD AVE, SILVER SPRING, MD</i>					
31. DATE FILED (Month, Day, Year) <i>SEP 30 1994</i>		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30041

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REV. JAMES M. FORKER				2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1994		3. TIME OF DEATH 3:45 p. M	
4. SOCIAL SECURITY NUMBER 148-26-2823		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 9, 1932	
8. BIRTHPLACE (State or Foreign Country) BAYONNE, NJ				9a. FACILITY NAME (If not institution, give street and number) 9209 E COLLEGE LANE		9b. CITY, TOWN OR LOCATION OF DEATH EMMITSBURG	
9c. COUNTY OF DEATH FREDERICK				10a. STATE MARYLAND		10b. COUNTY FREDERICK	
10c. CITY, TOWN OR LOCATION EMMITSBURG				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9209 E COLLEGE LANE	
10f. ZIP CODE 21727				10g. CITIZEN OF WHAT COUNTRY? U. S. A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CATHOLIC PREIST				16b. KIND OF BUSINESS/INDUSTRY MT. ST. MARY'S COLLEGE EDUCATION			
17. FATHER'S NAME (First, Middle, Last) COLUMB FORKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN GALLAGHER			
19a. INFORMANT'S NAME (Type/Print) THOMAS J. MULLELLY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MT. ST. MARY'S COLLEGE, EMMITSBURG, MD. 21727			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. ANTHONY'S SHRINE			
20c. LOCATION — City or Town, State EMMITSBURG, MD.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE John M. Skiles			
22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Acute Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Diffuse Coronary Artery Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus — insulin dependent SIP amputation both legs BK			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Alan Carroll M.D.			
29c. LICENSE NUMBER D 18705				29d. DATE SIGNED (Month, Day, Year) SEPT. 29, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN CARROLL, M.D. S. SETON AVE., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE John Swickard			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30042

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RAY GASS				2. DATE OF DEATH MONTH 09 DAY 25 YEAR 94		3. TIME OF DEATH 10:15 A.M.	
4. SOCIAL SECURITY NUMBER 579-05-6145		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 8 1909	
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 6121 Montrose Road			
10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson		16b. KIND OF BUSINESS/INDUSTRY Ladies Dress Shop	
17. FATHER'S NAME (First, Middle, Last) Gatsil Ben Echel Ballan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hinda Machle			
19a. INFORMANT'S NAME (Type/Print) Moses Gass				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6121 Montrose Road Rockville, MD. 20852			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beth Shalom Cemetery		20c. LOCATION — City or Town, State 9/26 Capital Hgts., MD.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARRHYTHMIAS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION DIABETES MELLITUS							Approximate Interval Between Onset and Death SUDDEN
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES MELLITUS							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Staff Physician				29c. LICENSE NUMBER D18084		29d. DATE SIGNED (Month, Day, Year) 9/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.D. PATEL, M.D. 6121 Montrose Rd, Rockville, MD 20852							
31. DATE FILED (Month, Day, Year) SEP 26 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

NOV 17 1964

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15

94 30043

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Vivian D. Giesey				2. DATE OF DEATH MONTH DAY YEAR Sept 21 99		3. TIME OF DEATH HOURS MIN. 7 10pm	
4. SOCIAL SECURITY NUMBER 716-18-0303		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	7. DATE OF BIRTH MONTH DAY YEAR MAY 13, 1898		8. BIRTHPLACE (State or Foreign) NEW YORK	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GAITHERSBURG	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 301 RUSSELL AVENUE			
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY RAILROAD			
17. FATHER'S NAME (First, Middle, Last) HERBERT J. KLINE				18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE LeGRAND			
19a. INFORMANT'S NAME (Type/Print) V. D. GIESEY (RECORDS)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMETERY 9/27 ARLINGTON, VA.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LATONSVILLE, MARYLAND			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonitis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate interval Between Onset and Death 2d.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James R. Moore, MD				29c. LICENSE NUMBER 07231		29d. DATE SIGNED (Month, Day, Year) Sept 22, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Moore, Jr. 207 Brookes Ave Gaithersburg MD 20877							
31. DATE FILED (Month, Day, Year) SEP 26 1994		32. REGISTRAR'S SIGNATURE J. Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30044

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Regina Mae Godfrey</u>				2. DATE OF DEATH MONTH <u>September</u> DAY <u>29</u> YEAR <u>94</u>		3. TIME OF DEATH <u>10:30 A</u> M	
4. SOCIAL SECURITY NUMBER <u>214-48-9629</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>88</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>November 19, 1905</u>	
8. BIRTHPLACE (State or Foreign Country) <u>West Virginia</u>				9a. FACILITY NAME (If not institution, give street and number) <u>903 Strauss Avenue (residence)</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Indian Head</u>	
9c. COUNTY OF DEATH <u>Charles</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Charles</u>	
10c. CITY, TOWN OR LOCATION <u>Indian Head</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>903 Strauss Ave.</u>	
10f. ZIP CODE <u>20640</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>William Morgan Davis</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Sarah Wright</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Georgie Chaney</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Same as #10</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Trinity Memorial Gardens Oct. 1, 1994</u>			
20c. LOCATION — City or Town, State <u>Waldorf, Maryland</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>W. J. F. M. 0668</u>			
22. NAME AND ADDRESS OF FACILITY <u>Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md. 20640</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Heart Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <u>Myocardial infarction</u> b. <u>Arteriosclerotic Heart Disease</u> c. <u>Arteriosclerotic Heart Disease</u> d. <u>Arteriosclerotic Heart Disease</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u>Hospice</u>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <u>N/A</u>			
28b. TIME OF INJURY <u>N/A</u>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <u>N/A</u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>N/A</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Abdul Fadul</u>				29c. LICENSE NUMBER <u>D-15765</u>			
29d. DATE SIGNED (Month, Day, Year) <u>9-30-1994</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Abdul Fadul MD 18 North Highway 301 Suite 101 LaPlata MD. 20646</u>			
31. DATE FILED (Month, Day, Year) <u>9-30-94</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30045

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Roland C Grimes Sr.</i>				2. DATE OF DEATH MONTH <i>9</i> DAY <i>30</i> YEAR <i>94</i>		3. TIME OF DEATH <i>9:20 AM</i>	
4. SOCIAL SECURITY NUMBER <i>215-26-2159</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 12, 1907</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Montgomery County General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Olney</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Ashton</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1500 Tucker Lane</i>				10f. ZIP CODE <i>20861</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W. II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Feed Supplier</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Harry Grimes</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Minnie Grimes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Julia McQuay Grimes</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1500 Tucker Lane, Ashton, MD 20861</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Carroll Crematory</i>		DATE <i>10/3</i>		20c. LOCATION — City or Town, State <i>Hampstead, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Swann & Lahey & Myers</i>				22. NAME AND ADDRESS OF FACILITY <i>Myers Funeral Home</i> <i>91 Willis St, Westminster, MD 21157</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dabets</i> <i>CAD</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur Schoengold</i>				29c. LICENSE NUMBER <i>D18726</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/30/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Arthur Schoengold, M.D. 18111 Prince Phillip Drive, Olney, MD 20832</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 03 1994</i>				32. REGISTRAR'S SIGNATURE <i>J. D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended Items 106-20A
10/3/94 *Shirley Campbell*

94 30046

1. FOR STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dennis Michael Graybill				2. DATE OF DEATH 9 29 94		3. TIME OF DEATH 1:30 PM	
4. SOCIAL SECURITY NUMBER 213-36-9873		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	7. DATE OF BIRTH (Month, Day, Year) 9/24/37		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) (by) Jasontown Road				9b. CITY, TOWN OR LOCATION OF DEATH Uniontown		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 36 Hillside Court				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN		16b. KIND OF BUSINESS/INDUSTRY Springfield Hospital			
17. FATHER'S NAME (First, Middle, Last) Daniel Light Graybill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Mary Gernet			
19a. INFORMANT'S NAME (Type/Print) Hazel Graybill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Hillside Court, Westminster, MD 21157			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations, Inc. Hampstead, MD		20c. LOCATION — City or Town, State Hampstead, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pitts-Sweitzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carbon Monoxide poisoning Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death terminal							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO N/A							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER 105905		29d. DATE SIGNED (Month, Day, Year) 29 Sept 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD JONES MD CARROLL COUNTY GENERAL HOSPITAL, WESTMINSTER, MD							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000

NOTES

RECORD

SECTION

(R)

X

RECORD

SECTION

NOTES

94 30047

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DAVID L GIGGARD				2. DATE OF DEATH SEPTEMBER 30, 1994		3. TIME OF DEATH 01:17 P.M.	
4. SOCIAL SECURITY NUMBER 218-84-8308		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 27 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec 28, 1966	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Taneytown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13 Courtland Street				10f. ZIP CODE 21787		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Lab Assistant		16b. KIND OF BUSINESS/INDUSTRY Maryland State Dept of Health			
17. FATHER'S NAME (First, Middle, Last) William Giggard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Buchman			
19a. INFORMANT'S NAME (Type/Print) June Wanda Giggard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Courtland St, Taneytown, MD 21787			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Carroll Cremations		DATE 10/1		20c. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Liver failure DUE TO (OR AS A CONSEQUENCE OF):					
		b. Hepatitis C DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. common variable immune deficiency DUE TO (OR AS A CONSEQUENCE OF):					
		d. sepsis					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mark Lewis M.D.				29c. LICENSE NUMBER M6321		29d. DATE SIGNED (Month, Day, Year) 9/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Lewis M.D. 110 Tower Johns Hopkins Hosp Balto Md 21205							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1

9/27/94

MRT

Montgomery County

94 30048

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Francis Griffin Griffin				2. DATE OF DEATH MONTH DAY YEAR 9/24/94		3. TIME OF DEATH 0034 AM			
4. SOCIAL SECURITY NUMBER 012-16-4983		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1922 February 28,		8. BIRTHPLACE (State or Foreign Country) Massachusetts	
9a. FACILITY NAME (If not Institution, give street and number) Howard County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia			9c. COUNTY OF DEATH Howard		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Clarksville			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 5478 Harris Farm Lane				10f. ZIP CODE 21029		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Special Agent			15b. KIND OF BUSINESS/INDUSTRY F.B.I. Federal Government		
17. FATHER'S NAME (First, Middle, Last) Patrick John Griffin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Frances Hayes					
19a. INFORMANT'S NAME (Type/Print) Helen Marie Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5478 Harris Farm Lane Clarksville, Maryland 21029					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 9/27/94		DATE 9/27/94		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Resp. failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): CHF b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO CONtribute TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Gary Karlow MD				29c. LICENSE NUMBER 041617		29d. DATE SIGNED (Month, Day, Year) 9/24/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary Karlow MD Columbia Medical CTR									
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30049

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise Victoria Green				2. DATE OF DEATH MONTH DAY YEAR September 24 1994		3. TIME OF DEATH 11:59 A M	
4. SOCIAL SECURITY NUMBER 577-32-0153		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1923	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 608 Douglas Avenue				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Hopson Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Swailes			
19a. INFORMANT'S NAME (Type/Print) Mildred Steward (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9404 Sierra Street, SilverSpring, MD 20903			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Pk. 9/29		20c. LOCATION — City or Town, State Rockville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory failure. DUE TO (OR AS A CONSEQUENCE OF):					
		b. Intra cerebral hematoma DUE TO (OR AS A CONSEQUENCE OF):					
		c. Hypertension DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James M.D.</i>				29c. LICENSE NUMBER D37891		29d. DATE SIGNED (Month, Day, Year) 9.24.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. RAJIVANSHI M.D. 121 CONGRESSIONAL LANE #409 Rockville MD 20852							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, 9/27/94, MRT Montgomery County 94 30050

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANDREW JUSTIN GARDE				2. DATE OF DEATH MONTH SEPT DAY 22 YEAR 94		3. TIME OF DEATH 11 09 A	
4. SOCIAL SECURITY NUMBER 143-72-8927		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 25, 1978	
8. BIRTHPLACE (State or Foreign Country) New Jersey				9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Darnestown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12629 Carrington Hill Drive	
10f. ZIP CODE 20878				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY High School	
17. FATHER'S NAME (First, Middle, Last) James Christopher Garde				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen Louise McDonald			
19a. INFORMANT'S NAME (Type/Print) James C. Garde				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12629 Carrington Hill Dr., Darnestown, MD. 20878			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Valleau Cemetery 9/27/94		20c. LOCATION — City or Town, State Ridgewood, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gibbons</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 24 HR	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 9 21 94		28b. TIME OF INJURY 1700 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED T BORE MVA		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) QUINCE ORANGE WOODER VIEW		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Mayhew</i>				29c. LICENSE NUMBER D07094		29d. DATE SIGNED (Month, Day, Year) 9-22-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Mayhew 10215 Fernwood Rd Bethesda MD 20817 1106							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) Walter Benjamin Gibson				2. DATE OF DEATH MONTH DAY YEAR Sept. 20 1994		3. TIME OF DEATH 6:45 A M	
4. SOCIAL SECURITY NUMBER 577-07-7763		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 31, 1903	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not Institution, give street and number) 525 Thayer Avenue #105				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 525 Thayer Avenue #105				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Service Technician		16b. KIND OF BUSINESS/INDUSTRY Washington Gas Company			
17. FATHER'S NAME (First, Middle, Last) Unobtainable				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable			
19a. INFORMANT'S NAME (Type/Print) Eva H. Gibson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Thayer Avenue #105 Silver Spring, Maryland 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		DATE 9/22		20c. LOCATION — City or Town, State Suitland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Andrew J. Furthman</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia							
b. Cardiovascular disease							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Shumacher MD</i>				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) 9/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shumacher MD 2309 Shorefield Rd Wheaton 20902							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-18 Rev 1/89

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2000

94 30053

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUGENE GAYNOR				2. DATE OF DEATH MONTH 9 DAY 16 YEAR 94		3. TIME OF DEATH 7: 00 A	
4. SOCIAL SECURITY NUMBER 220-12-1569		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-20-1915	
9a. FACILITY NAME (If not institution, give street and number) 120 FLOWER STREET				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 120 FLOWER STREET				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY RETIRED-SHOWELL POULTRY FAR.			
17. FATHER'S NAME (First, Middle, Last) SAM GAYNOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLOSSIE CLOSE			
19a. INFORMANT'S NAME (Type/Print) EVELYN WHALEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11836 STEAM MILL HILL RD., WHALEYVILLE, MD. 21872			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) EVERGREEN, BERLIN		DATE 9-20		20c. LOCATION — City or Town, State BERLIN, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i>				22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL, 1213 JERSEY ROAD, SALISBURY, MD. 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepato renal Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Cancer of Pancreas with obstructive jaundice DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus - Artificial valve							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kota L Chandrasekhara MD</i>				29c. LICENSE NUMBER D25091		29d. DATE SIGNED (Month, Day, Year) 9/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KOTA L CHANDRASEKHARA MD 306 KAY AVE SALISBURY MD 21801							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended:

9a, 10e, 9-28-94, plh, Cecil County

94 30054

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Walter G Gilman						2. DATE OF DEATH MONTH DAY YEAR Sept 19 1994		3. TIME OF DEATH 11:57a M		
4. SOCIAL SECURITY NUMBER 148-10-6786		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7. DATE OF BIRTH (Month, Day, Year) Sept 9 1913						8. BIRTHPLACE (State or Foreign Country) New Jersey				
9a. FACILITY NAME (If not institution, give street and number) 80 Lums Pond Rd						9b. CITY, TOWN OR LOCATION OF DEATH North East			9c. COUNTY OF DEATH Cecil	
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 80 Lums Pond Rd 35 Rolling Mill Rd						10f. ZIP CODE 21901		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 12 College (1-4 or 5+) 1				15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman			15b. KIND OF BUSINESS/INDUSTRY Retail			
17. FATHER'S NAME (First, Middle, Last) Walter Gilman						18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Spear				
19a. INFORMANT'S NAME (Type/Print) Jacqueline Poore						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2064 Theodore Rd Rising Sun MD 21911				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St Mary Anne's 9-22-1994		OATE		20c. LOCATION — City or Town, State North East MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home P O Box 27 Chesapeake City MD 21915				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>malnutrition and Pneumonia</i> b. <i>occult metastatic carcinoma</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER MD						29c. LICENSE NUMBER D44102		29d. DATE SIGNED (Month, Day, Year) 9/20/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William F. RENZULLI, M.D. 901 WARBURTON RD, EIGHTH MD BETHESDA 21921										
31. DATE FILED (Month, Day, Year) SEP 21 '94		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30055

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen F Grooms				2. DATE OF DEATH MONTH DAY YEAR September 28 1994		3. TIME OF DEATH 4:45 PM	
4. SOCIAL SECURITY NUMBER 578-20-8620		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-28-1914	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Clarksburg		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24301 Peachtree Road				10f. ZIP CODE 20871		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) Otis G. VanWormer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katie Hungerford			
19a. INFORMANT'S NAME (Type/Print) Dollie Sherman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24301 Peachtree Rd. Clarksburg, Md. 20871			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Barnabus Episcopal		DATE 10-4		20c. LOCATION — City or Town, State Temple Hills, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.D. D.L.				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Box 86 Barnesville, Md. 20838			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. COP PULMONARY DUE TO (OR AS A CONSEQUENCE OF):							
b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Carl I. Schenberger MD				29c. LICENSE NUMBER D26570		29d. DATE SIGNED (Month, Day, Year) Sept 28 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carl I. Schenberger MD 16220 Frederick Rd. Gaithersburg MD.							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE John Davidson Rusk			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30056

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM WILKES GRIFFIN, JR.				2. DATE OF DEATH MONTH DAY YEAR Oct. 3, 1994		3. TIME OF DEATH 5:20 P.M.	
4. SOCIAL SECURITY NUMBER 117-14-2552		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/25/1921	
9a. FACILITY NAME (If not institution, give street and number) 7102 Hillside Circle				9b. CITY, TOWN OR LOCATION OF DEATH Thurmont		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 7102 Hillside Circle				10f. ZIP CODE 21788		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII and Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) United States Marine Corp		15b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) William Wilkes Griffin, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eugenia Wheeler Griffin			
19a. INFORMANT'S NAME (Type/Print) Florence Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7102 Hillside Circle, Thurmont, MD 21788			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Quantico National Cem. 10/4/94		20c. LOCATION — City or Town, State Quantico, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ryan M. Burger</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home P.O. Box 1819, Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Septic shock</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Welder 50-2000</i> <i>10/4/94</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory P. Rausch</i>				29c. LICENSE NUMBER D14626		29d. DATE SIGNED (Month, Day, Year) 10/4/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gregory P. Rausch, M.D. 501 West 7th Street Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE <i>John A. Rausch</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

FROM

TO

94 30057

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAUL R GROSHON				2. DATE OF DEATH MONTH 10 DAY 06 YEAR 94		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 214-26-0040		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 2, 1906	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) PLEASANT VIEW NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH MT. AIRY	
9c. COUNTY OF DEATH CARROLL				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION LAYTONSVILLE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6020 GRIFFITH ROAD	
10f. ZIP CODE 20882				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE		16b. KIND OF BUSINESS/INDUSTRY SCHOOL SYSTEMS	
17. FATHER'S NAME (First, Middle, Last) CLARENCE GROSHON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSA CRAVER			
19a. INFORMANT'S NAME (Type/Print) FLORENCE RAU				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LAYTONSVILLE CEMETERY 10/8		20c. LOCATION — City or Town, State LAYTONSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 PO Box 5038 LAYTONSVILLE, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS a. DUE TO (OR AS A CONSEQUENCE OF): b. UTI probable c. DUE TO (OR AS A CONSEQUENCE OF): d. clay Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Decubita, Htn, spinal stenosis hypertension							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER DR. MELVIN KORDON			
29c. LICENSE NUMBER 82 006580				29d. DATE SIGNED (Month, Day, Year) 10/7/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4801 Dorsey Hall Dr Ellwood City MD 21042							
31. DATE FILED (Month, Day, Year) OCT 12 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Aug 10 1880

Aug 10 1880

Received of H. B. ...

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94-5536-031

B.K.S

94 30058

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEWIS WILBURN HOOVER			2. DATE OF DEATH SEPT. 23 1994		3. TIME OF DEATH 4:30 P M
4. SOCIAL SECURITY NUMBER 237-07-6285	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	8. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH July 9, 1912		6. BIRTHPLACE (State or Foreign Country) No. Carolina
9a. FACILITY NAME (If not institution, give street and number) GRETER MONTGOMERY GEN. HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT					
10a. STATE Maryland	10b. COUNTY Howard	10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8325 Sweet Cherry Lane		10f. ZIP CODE 20723		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian		16b. KIND OF BUSINESS/INDUSTRY City Government	
17. FATHER'S NAME (First, Middle, Last) Lee Hoover			16. MOTHER'S NAME (First, Middle, Maiden Surname) Julie Walker		
19a. INFORMANT'S NAME (Type/Print) Althea C. Hoover (Wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8325 Sweet Cherry Lane, Laurel, MD 20723			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Good Hope Cemetery 9/28		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>		22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 9-23-94		28b. TIME OF INJURY 1410 M	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED Motor vehicle collision	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Rt 29 and 190	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>			29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) SEPT. 24, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) SEP 27 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

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94 30059

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emma Helen Henlock				2. DATE OF DEATH MONTH DAY YEAR September 24, 1994		3. TIME OF DEATH 1:30 PM	
4. SOCIAL SECURITY NUMBER 214-34-6365		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 26, 1897	
8. BIRTHPLACE (State or Foreign Country) Virginia				9. FACILITY NAME (If not institution, give street and number) 9005 Woodland Drive			
10. CITY, TOWN OR LOCATION OF DEATH Silver Spring				11. COUNTY OF DEATH Montgomery			
12. RESIDENCE OF DECEDENT 10a. STATE Maryland				13. 10b. COUNTY Montgomery			
14. 10c. CITY, TOWN OR LOCATION Silver Spring				15. 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
16. 10e. STREET AND NUMBER 9005 Woodland Drive				17. 10f. ZIP CODE 20910			
18. 10g. CITIZEN OF WHAT COUNTRY? U.S.A.				19. 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			
20. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				21. 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
22. 14. RACE — American Indian, Black, White, etc. Specify: White				23. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			
24. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse				25. 16b. KIND OF BUSINESS/INDUSTRY Health Care			
26. 17. FATHER'S NAME (First, Middle, Last) William Thomas Dod				27. 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Belle Trevy			
28. 19a. INFORMANT'S NAME (Type/Print) Louise Lilly Daly				29. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1737 Irving Street, N.W. Washington, D.C. 20010			
30. 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				31. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 9/27/94			
32. 20c. LOCATION — City or Town, State Brentwood, Maryland				33. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey			
34. 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901				35. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>generalized arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 10 yrs			
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				37. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				39. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
40. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				41. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
42. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				43. 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
44. 28d. DESCRIBE HOW INJURY OCCURRED				45. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
46. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				47. 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
48. 29a. SIGNATURE AND TITLE OF CERTIFIER George F. Sengstack				49. 29b. LICENSE NUMBER D12121			
50. 29c. DATE SIGNED (Month, Day, Year) SEP 27 1994				51. 29d. DATE SIGNED (Month, Day, Year) 9-26-94			
52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE F. SENGSTACK, MD 3929 FERRARA DRIVE, WHEATON, MD 20906				53. 31. DATE FILED (Month, Day, Year) SEP 27 1994			
54. 32. REGISTRAR'S SIGNATURE John Davidson-Randall				55. 33. DATE SIGNED (Month, Day, Year)			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30060

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Newton HENSON				2. DATE OF DEATH MONTH DAY YEAR OCT 7 94		3. TIME OF DEATH 1225 M	
4. SOCIAL SECURITY NUMBER 219-05-2101		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 22, 1906	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 384 S. Cannon Avenue			
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supt. of Street & Inspector		15b. KIND OF BUSINESS/INDUSTRY City of Hagerstown			
17. FATHER'S NAME (First, Middle, Last) Benjamin Henson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Rutherford			
19a. INFORMANT'S NAME (Type/Print) Donna Spigler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Guilford Avenue Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Memorial Park 10-10-94		20c. LOCATION — City or Town, State Williamsport, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIOPULMONARY ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>EMBOLUS LEFT LEG</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>END STAGE PULMONARY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>SEVERE AORTIC STENOSIS + ATRIAL FIBRILLATION</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COLON CARCINOMA</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER D44471		29d. DATE SIGNED (Month, Day, Year) 10/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ILANA ROBBINS, 11110 MEDICAL CAMPUS RD, HAGERSTOWN, MD 21742							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30061

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES LINWOOD HARTMAN				2. DATE OF DEATH MONTH October DAY 7 YEAR 1994		3. TIME OF DEATH 10:30 P M	
4. SOCIAL SECURITY NUMBER 214-09-9169		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1917	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1005 Beechwood Drive				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. Army WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Charles Hartman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Reamer			
19a. INFORMANT'S NAME (Type/Print) Murray Delauter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 FanFare N.E. Palm Bay, Florida 32907			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 10-10-94		20c. LOCATION — City or Town, State Hagerstown, Maryland		22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Left Lung DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Brain Metastases DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward W. Ditto</i>				29c. LICENSE NUMBER D01062		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD.. 21740							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>Julius Sanders</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30062

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sara A. Hartman				2. DATE OF DEATH MONTH 09 DAY 30 YEAR 94		3. TIME OF DEATH 1:25 P M	
4. SOCIAL SECURITY NUMBER 80-07-2762		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-6-10	8. BIRTHPLACE (State or Foreign Country) PA.		
9a. FACILITY NAME (If not institution, give street and number) BERLIN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION OCEAN CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12503 WHISPER TRACE RD.				10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) FRANK YOST				18. MOTHER'S NAME (First, Middle, Maiden Surname) LETTA LEIDY			
19a. INFORMANT'S NAME (Type/Print) DONALD N. HARTMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12503 WHISPER TRACE RD. OCEAN CITY, MD, 21842			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MILTON CEMETERY DATE 10/5		20c. LOCATION — City or Town, State MILTON, PA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Ullrich</i>				22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD., 21			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute coronary Occlusion Approximate interval Between Onset and Death 10 minutes Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease 4 years Atherosclerosis 7 years Dise							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pace Single Dementia				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Federico G. Arthes</i>				29c. LICENSE NUMBER D02026		29d. DATE SIGNED (Month, Day, Year) 9-30-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811 410-6416363							
31. DATE FILED (Month, Day, Year) OCT 04 1994		32. REGISTRAR'S SIGNATURE <i>John S. Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Amended #206 9/28/94 MRT Montgomery County 94 30063

FOR
STATE
REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beulah C. Hughes				2. DATE OF DEATH MONTH DAY YEAR September 26, 1994		3. TIME OF DEATH 5:15 P M	
4. SOCIAL SECURITY NUMBER 578-10-9956		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 30, 1897	
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5711 Rossmore Drive				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator		16b. KIND OF BUSINESS/INDUSTRY United States Post Office Department			
17. FATHER'S NAME (First, Middle, Last) William McCarthy Hughes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Haynes			
19a. INFORMANT'S NAME (Type/Print) J. Thomas Hughes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 Rossmore Drive, Bethesda, Maryland 20814			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 9/26/94 DATE		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMillen Lawrence M00831		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. atherosclerotic heart disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Walter Goozh, MD				29c. LICENSE NUMBER D01120		29d. DATE SIGNED (Month, Day, Year) September 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter Goozh, MD 2309 Shorefield Road, Wheaton, Maryland 20902							
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30064

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DUNCAN HAZLEWOOD				2. DATE OF DEATH MONTH 09 DAY 27 YEAR 94		3. TIME OF DEATH 1130A	
4. SOCIAL SECURITY NUMBER 402-36-0395		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1922	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Takoma Park		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 401 Beech Ave.				10f. ZIP CODE 20912		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Artist		16b. KIND OF BUSINESS/INDUSTRY Self employed	
17. FATHER'S NAME (First, Middle, Last) Thomas R. Hazlewood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Grebe			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Howland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Beech Ave. Takoma Park, MD 20912			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 9/28/94		20c. LOCATION — City or Town, State Alexandria, VA		20d. DATE 9/28/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D08546		29d. DATE SIGNED (Month, Day, Year) 9-27-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tamber 8218 W. S. CARLIN AVE Bethesda							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30065

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGUERITE T. HAYES				2. DATE OF DEATH MONTH 9 DAY 22 YEAR 94		3. TIME OF DEATH 8 PM	
4. SOCIAL SECURITY NUMBER 173-20-3614		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-16-1914	
8. BIRTHPLACE (State or Foreign Country) MAINE				9a. FACILITY NAME (If not institution, give street and number) Pleasant View Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy	
9c. COUNTY OF DEATH CARROLL				10a. STATE MARYLAND			
10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BROOKEVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3301 DAMASCUS ROAD	
10f. ZIP CODE 20833		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY	
16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT		17. FATHER'S NAME (First, Middle, Last) TIMOTHY EDWARD HAYES		18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY LOUISE DOUGHERTY		19a. INFORMANT'S NAME (Type/Print) LOUISE K. ZACHARIAS	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN		20c. LOCATION — City or Town, State SILVER SPRING, MD.	
20d. DATE 9/26		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>		22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P O BOX 5038 LAYTONSVILLE, MARYLAND		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. dissecting aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): b. Heart failure CHF DUE TO (OR AS A CONSEQUENCE OF): c. beakitis DUE TO (OR AS A CONSEQUENCE OF): d. neural failure	
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fib, COPD		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M	
26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Muriel H. Barber</i>		29c. LICENSE NUMBER 006588		29d. DATE SIGNED (Month, Day, Year) 9/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4801 Drexley Hall Dr Ellicott City Md 21042		31. DATE FILED (Month, Day, Year) SEP 26 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>		33. SIGNATURE AND TITLE OF CERTIFIER <i>Muriel H. Barber</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10000

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Amended #20c 9/26/94 MRT Montgomery County
 1. FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

94 30066

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERTHA HILDEBRAND				2. DATE OF DEATH MONTH DAY YEAR 09/23/94		3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER 119-18-6491		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 12 1898	
8. BIRTHPLACE (State or Foreign Country) Estonia				9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7002 Tilden Lane	
10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) Homemaker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own home	
17. FATHER'S NAME (First, Middle, Last) Nathen Wendroff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna (unknown)			
19a. INFORMANT'S NAME (Type/Print) Bernard Hildebrand				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7002 Tilden Lane Rockville, MD. 20852			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Park Cemetery 9/25		20c. LOCATION — City or Town, State Westwood Emerson, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multi infarct Dementia Approximate interval Between Onset and Death YRS. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Staff Physician				29c. LICENSE NUMBER D15084		29d. DATE SIGNED (Month, Day, Year) 9/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.D. PATEL, MD 6121 Montrose Rd Rockville, MD 20852							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30067

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) D'MARGIO HOPKINS				2. DATE OF DEATH MONTH 09 DAY 26 YEAR 94		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 214-33-6653		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 3 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 19 91	
9a. FACILITY NAME (If not institution, give street and number) 452 GLEN MAR COURT APT. C2				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8193 VILLAGE ROAD				10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? USA.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) ANTHONY HEADLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROXANNE HOPKINS			
19a. INFORMANT'S NAME (Type Print) ROXANNE HOPKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8193 VILLAGE RD SEVERN, MD 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 9/29/94		20c. LOCATION — City or Town, State ANNAPOLIS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest. DUE TO (OR AS A CONSEQUENCE OF): b. NEUROBLASTOMA. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 yr.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Maria Pelidis MD</i>				29c. LICENSE NUMBER D44903		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIA PELIDIS 600N WOLFE ST. BALTIMORE MD 21287							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30068

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nan Edith Wheeler Hatch				2. DATE OF DEATH MONTH DAY YEAR Sept 26 1994		3. TIME OF DEATH 5:30A M	
4. SOCIAL SECURITY NUMBER 212-34-3932		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 25 1913	
9a. FACILITY NAME (If not institution, give street and number) 92 Conduit Street				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 92 Conduit Street				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Register of Wills		16b. KIND OF BUSINESS/INDUSTRY Anne Arundel County Government			
17. FATHER'S NAME (First, Middle, Last) John Alfred Wheeler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Neal Wallis			
19a. INFORMANT'S NAME (Type/Print) Ann K. Hatch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1082 Hillrise Court Las Cruces, NM 88011			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Marks Cemetery 9/29/94		20c. LOCATION — City or Town, State Silver Spring, Maryland		22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>pancreatic cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jack R. Lichtenstein</i>				29c. LICENSE NUMBER D08194		29d. DATE SIGNED (Month, Day, Year) September 26 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jack R. Lichtenstein, M.D. 207 Ridgley Avenue Annapolis, Maryland 21401							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30069

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GERTRUDE MARY HULL				2. DATE OF DEATH MONTH September DAY 20 YEAR 1994				3. TIME OF DEATH 1156 M	
4. SOCIAL SECURITY NUMBER 219-05-3533		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) 7/7/1919				8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Tyaskin				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 21548 Wetipquin Road				10f. ZIP CODE 21865		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 				15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			15b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Thomas T. Hackett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Amelia Handy					
19a. INFORMANT'S NAME (Type/Print) Ronald W. Hull				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Cook Drive, Salisbury, Md. 21801					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Tyaskin Cemetery		DATE 9/24/94		20c. LOCATION — City or Town, State Tyaskin, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MOO-417				22. NAME AND ADDRESS OF FACILITY Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814					
23. PART I. Enter the disease(s), or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul R. Fleury</i>				29c. LICENSE NUMBER D24872	
				29d. DATE SIGNED (Month, Day, Year) 9/21/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL FLEURY 5200 Riverchase Dr SALISBURY Md 21801									
31. DATE FILED (Month, Day, Year) SEP 22 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



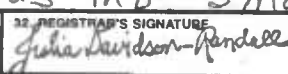
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

James M. Brown

94 30070

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harold Jacob Hale				2. DATE OF DEATH MONTH DAY YEAR September 24 1994		3. TIME OF DEATH 17:17 M	
4. SOCIAL SECURITY NUMBER 173 - 07 - 0443		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 28, 1917	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Charlestown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17 Pennsylvania Avenue				10f. ZIP CODE 21914		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Water Test Repairman		15b. KIND OF BUSINESS/INDUSTRY Auto Manufacturing			
17. FATHER'S NAME (First, Middle, Last) John Henry Hale				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amy Rebecca Congleton			
19a. INFORMANT'S NAME (Type/Print) Elizabeth M. Hale				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 62, Charlestown, MD 21914			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Hope Cemetery		20c. LOCATION — City or Town, State 9/28/94 Mt. Hope, Pennsylvania			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate interval Between Onset and Death MINUTES
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TYPE OF CERTIFIER 				29c. LICENSE NUMBER 0-44783		29d. DATE SIGNED (Month, Day, Year) 9-25-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Monte Makous MD 3 Mauldin Ave. North East, Md. 21901							
31. DATE FILED (Month, Day, Year) SEP 26 '94		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30071

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jacob CHARLES HARTMAN				2. DATE OF DEATH MONTH SEPTEMBER DAY 29 YEAR 1994		3. TIME OF DEATH 4:07 P.M.	
4. SOCIAL SECURITY NUMBER 217-16-2103		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH Month, Day, Year Nov 28, 1923				8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1078 Carlton Place, Apt 1-A				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11/19/1943-8/15/1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bricklayer		16b. KIND OF BUSINESS/INDUSTRY Contruction			
17. FATHER'S NAME (First, Middle, Last) Edward Leon HARTMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Matilda Letitia AYERS			
19a. INFORMANT'S NAME (Type/Print) Mrs. M. Louise Hartman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1078 Carlton Place, Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 10/3/94		20c. LOCATION — City or Town, State Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith L. Robertson</i> MO0706				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ARDS - adult respiratory distress syndrome</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>GI bleed</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>liver failure</u>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 10 yrs 2 mos 2 mos 10 yrs					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Type 2 OM</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee M Krug MD</i>				29c. LICENSE NUMBER M6302		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee M Krug MD 600 N. Wolfe St Bkts Md 21207							
31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE <i>Jacob Charles Hartman</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #4

MRT

10/12/94

Montgomery County

94 30072

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Zela Moorings Jackson				2. DATE OF DEATH MONTH 10 DAY 07 YEAR 94		3. TIME OF DEATH 5:45A	
4. SOCIAL SECURITY NUMBER 235-86-6106		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In years, last birthday) 90 YRS.		7. DATE OF BIRTH 11/4/04	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Severna Park		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 485 Fair Oaks Drive				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fr Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Frank Dennis Mooring				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Margaret Johnson			
19a. INFORMANT'S NAME (Type/Print) Jane Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Lawn Cemetery		20c. LOCATION — City or Town, State 10/10 Pecksmill, West Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 1yr	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Chronic Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF):				3yr	
		c. Carcinoma of Palate DUE TO (OR AS A CONSEQUENCE OF):				10yr	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jon B. Lowe MD				29c. LICENSE NUMBER D18529		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jon B. Lowe MD, 600 KIDGELY AVE, ANNAPOLIS, MD 21401							
31. DATE FILED (Month, Day, Year) OCT 12 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30073

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernice E. Johnson				2. DATE OF DEATH MONTH 09 DAY 29 YEAR 94		3. TIME OF DEATH 0640A	
4. SOCIAL SECURITY NUMBER 213-38-3911		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/29/41	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 16601 Candy Hill Road			
10f. ZIP CODE 20772				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educator		16b. KIND OF BUSINESS/INDUSTRY School System/ Board of Education			
17. FATHER'S NAME (First, Middle, Last) John S. Washington, Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary D. Gray			
19a. INFORMANT'S NAME (Type/Print) Richard A. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16601 Candy Hill Rd., Upper Marlboro, MD. 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cem 10/3/94		20c. LOCATION — City or Town, State Clinton, Maryland		20d. DATE 10/3/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lloyd M. Estep				22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, PA Aquasco Road, Aquasco, MD. 20608			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): c. Sepsis DUE TO (OR AS A CONSEQUENCE OF): d. Urinary Tract Infection					
Approximate interval Between Onset and Death Sudden Days Days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebro Vascular Accident thrombotic thrombo cytopenic purpura							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Refusa ms		29c. LICENSE NUMBER D-32332		29d. DATE SIGNED (Month, Day, Year) 09 29 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SK GUPTA 1801 Georgia Ave #220 Silver Spring Md 20902							
31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE Julia Pawlson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30074

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Edward Johnson				2. DATE OF DEATH MONTH 10 DAY 09 YEAR 94		3. TIME OF DEATH 8:20 a.m.	
4. SOCIAL SECURITY NUMBER 215-18-1902		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 18, 1910	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. COUNTY OF DEATH Washington			
9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Home, Inc.				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 11510 Greenberry Road				10i. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Boiler Tech.		16b. KIND OF BUSINESS/INDUSTRY Dye & Finishing Co.			
17. FATHER'S NAME (First, Middle, Last) Cyrus Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Chesnut			
19a. INFORMANT'S NAME (Type/Print) Allan Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 N. Colonial Drive Hagerstown, Md. 21742			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Grove Cemetery 10-12-94		20c. LOCATION — City or Town, State Warfordsburg, Pa.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>	
22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pulmonary Edema</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>3 days</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive Pulmonary Disease</i> <i>Parkinson Disease</i> <i>Chronic Renal insufficiency</i> <i>Hypertension</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>V. State MD</i>				29c. LICENSE NUMBER D18019		29d. DATE SIGNED (Month, Day, Year) 10-9-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30075

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth NMN JENKINS				2. DATE OF DEATH MONTH DAY YEAR 10 09 94		3. TIME OF DEATH 0345 M	
4. SOCIAL SECURITY NUMBER 058-22-2120		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-8-26	
8. BIRTHPLACE (State or Foreign Country) New York				9. FACILITY NAME (If not institution, give street and number) Washington County Hospital		10. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
11. COUNTY OF DEATH Washington				12. RESIDENCE OF DECEDENT		13. COUNTY OF DEATH Washington	
14. STATE Maryland		15. COUNTY Washington		16. CITY, TOWN OR LOCATION Hagerstown		17. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
18. STREET AND NUMBER 20519 Trovinger Mill Road				19. ZIP CODE 21742		20. CITIZEN OF WHAT COUNTRY? U.S.A.	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Agent Account Executive		27. KIND OF BUSINESS/INDUSTRY Real Estate Radio Station			
28. FATHER'S NAME (First, Middle, Last) Mihran Markarian				29. MOTHER'S NAME (First, Middle, Maiden Surname) Mureny Hakoutonian			
30. INFORMANT'S NAME (Type/Print) Frederick M. Jenkins				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20519 Trovinger Mill Road Hagerstown, Md. 21742			
32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park 10-14-94		34. DATE 10-14-94		35. LOCATION — City or Town, State Hagerstown, Md.	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick				37. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest b. apparent myocardial infarction c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Use of antihist							
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>		41. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		42. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
43. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		44. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
45. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		46. DATE OF INJURY (Month, Day, Year)		47. TIME OF INJURY M		48. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
49. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		50. DESCRIBE HOW INJURY OCCURRED					
51. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
52. SIGNATURE AND TITLE OF CERTIFIER Harold R. Tuttle, M.D.				53. LICENSE NUMBER D 12194		54. DATE SIGNED (Month, Day, Year) 10/10/94	
55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 348 Mill St Hagerstown Md 21740							
56. DATE FILED (Month, Day, Year) OCT 11 1994		57. REGISTRAR'S SIGNATURE John D. Harrison					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30076

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRY RUSSELL JENKINS, JR.						2. DATE OF DEATH MONTH 10 DAY 4 YEAR 1994		3. TIME OF DEATH 5:55 M	
4. SOCIAL SECURITY NUMBER 579 03 5950		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 5, 1917		8. BIRTHPLACE (State or Foreign Country) Washington D.C.	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Ocean City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER #10 81st Street Unit #406						10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President Plumbing Co.		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Harry R. Jenkins, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Mary Drury			
19a. INFORMANT'S NAME (Type/Print) Stephen W. Jenkins						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433 Muddy Branch Rd. Apt. 102 Gaithersburg, MD			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park 10/8/94		DATE 10/8/94		20c. LOCATION — City or Town, State Berlin, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY BURBAGE FUNERAL HOME 108 Williams St. Berlin, MD 21811			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIAS									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MYOCARDIAL ISCHEMIA									
DUE TO (OR AS A CONSEQUENCE OF):									
DUE TO (OR AS A CONSEQUENCE OF):									
DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANOXIC ENCEPHALOPATHY									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven T. Kariva - MD</i>						29c. LICENSE NUMBER D36252		29d. DATE SIGNED (Month, Day, Year) 10/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN T. KARIVA, MD, 11501 GEORGETTA AVE, WHEATON MD 20902									
31. DATE FILED (Month, Day, Year) OCT 06 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



51



94 30077

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE T. JONES				2. DATE OF DEATH MONTH DAY YEAR SEPT. 26, 1994		3. TIME OF DEATH 7:18 A. M	
4. SOCIAL SECURITY NUMBER 083-36-2949		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 84		7. DATE OF BIRTH (Month, Day, Year) MAY. 15, 1900	
9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH OLNEY		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3701 INTERNATIONAL DRIVE			
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) POSTAL CLERK		16b. KIND OF BUSINESS/INDUSTRY U.S. POST OFFICE			
17. FATHER'S NAME (First, Middle, Last) GEORGE A. JONES				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE JENKINS			
19a. INFORMANT'S NAME (Type/Print) GLORIA J. MORRIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 INTERLACHEN DRIVE SILVER SPRING, MD. 20906			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		OATE 09/29		20c. LOCATION — City or Town, State BRONX, NY.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael S. Nelson</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVE. N.W. WASHINGTON, DC. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Fr of Rt Hip DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. Thaker</i>				29c. LICENSE NUMBER D43430		29d. DATE SIGNED (Month, Day, Year) 9/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GAURANG THAKER, 18111 PRINCE PHILIPPA #212 OLNEY MD 20832							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Edward Jewes</i>				2. DATE OF DEATH MONTH DAY YEAR <i>9 28 94</i>		3. TIME OF DEATH <i>12 Noon M</i>	
4. SOCIAL SECURITY NUMBER <i>214-32-1086</i>		5. SEX <i>1 M 2 F</i>		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-23-34</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Mallard Bay Nursing Home</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>		8c. COUNTY OF DEATH <i>Dorchester</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Cambridge</i>		10d. INSIDE CITY LIMITS? <i>1 YES 2 NO</i>	
10e. STREET AND NUMBER <i>520-Glenburn Ave.</i>				10f. ZIP CODE <i>21613</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (9-12) Grade 12</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Labor</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>James Edward Jewes</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Christine Elizabeth Vaughn</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Barbara Trader</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1016 Queen Ave, Salisbury, Md.</i>			
20a. METHOD OF DISPOSITION <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Old Field Cemetery 10/3</i>		20c. LOCATION — City or Town, State <i>Church Creek, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janelle C. Henry</i>				22. NAME AND ADDRESS OF FACILITY <i>HENRY FUNERAL HOME 510 Washington St. Cambridge, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>minutes</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>Dementia</i> <i>Peripheral Vascular Disease</i> <i>Peripheral Neuropathy</i>							
24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 NO</i>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 NO</i>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i>				26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>			
27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
				28c. INJURY AT WORK? <i>1 YES 2 NO</i>		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edmund J. MacLaughlin</i>				29c. LICENSE NUMBER <i>D-28209</i>		29d. DATE SIGNED (Month, Day, Year) <i>9-28-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Edmund J. MacLaughlin 10 Aurora St Cambridge Md 21613</i>							
31. DATE FILED (Month, Day, Year) <i>SEP 30 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Dawson Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

91

94 30079

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary P. Johnson				2. DATE OF DEATH MONTH 09 DAY 28 YEAR 94		3. TIME OF DEATH 0720 M	
4. SOCIAL SECURITY NUMBER 214-12-4069		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/19/22	
9a. FACILITY NAME (If not institution, give street and number) Dor. Gen. Hospital, Camb., Md.				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge, 21613		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Dor.		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 623 Wells St. Camb., Md.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yaa or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Blk.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) Seafood Worker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Richard Stanley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche WXXXX Waters Stanley			
19a. INFORMANT'S NAME (Type/Print) Paulette L. Jones Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Esquire Dr. Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Church Cem. Taylor's Is. 3-94 Taylor's Is., Md.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lewis H. Boardley				22. NAME AND ADDRESS OF FACILITY 812 Hubbard St. Cambridge, Md. 21613-410-228-7317			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cholangiocarcinoma							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Hypoglycemia							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Congestive Heart Failure							
DUE TO (OR AS A CONSEQUENCE OF):							
d. 1990							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE OF INJURY			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Vinodrai Mehta				29c. LICENSE NUMBER 015541		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Vinodrai Mehta, M.D. 400 Aurora Street Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE Julia Swanson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(34)



94 30080

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DESPINA KOVAKAS				2. DATE OF DEATH MONTH DAY YEAR Sept. 24, 1994		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 579.84.3652		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 18, 1913	
8. BIRTHPLACE (State or Foreign Country) FLOYDA, TURKEY				9a. FACILITY NAME (If not institution, give street and number) 6508 Western Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase	
9c. COUNTY OF DEATH Montgomery							
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION CHEVY CHASE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6508 WESTERN AVE.				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) GEORGE JOHNSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) VASILIKE IOANIDES			
19a. INFORMANT'S NAME (Type/Print) JAMES KOVAKAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5449 30th PLACE N.W. WASHINGTON D.C. 20015			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY		DATE 9/27		20c. LOCATION — City or Town, State BRENTWOOD, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Peters</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS 5130 WISCONSIN AVE. N.W. WASHINGTON D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 1 year 10 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Gustafson, M.D.</i>				29c. LICENSE NUMBER D-15049		29d. DATE SIGNED (Month, Day, Year) 9/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John F. Gustafson, M.D., 5480 Wisconsin Ave., Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

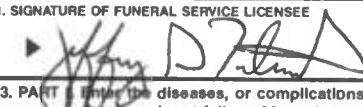

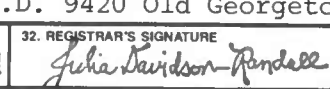
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30081

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Jenkins Kelly				2. DATE OF DEATH MONTH DAY YEAR September 26, 1994		3. TIME OF DEATH 1:15 A M	
4. SOCIAL SECURITY NUMBER 215 46 1285		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 5, 1904	
9a. FACILITY NAME (If not institution, give street and number) Manor Care-Potomac				9b. CITY, TOWN OR LOCATION OF DEATH Potomac		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9608 Singleton Drive				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Lewis Jenkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Burch			
19a. INFORMANT'S NAME (Type/Print) Carolyn M. O'Connor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Singleton Drive, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 9/28/94 DATE Ft. Lincoln Cemetery		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501			
23. PART I. Under the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST e. Hypostatic Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death 10 days 30 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24e. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D02047		29d. DATE SIGNED (Month, Day, Year) September 26, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph D. Connor, M.D. 9420 Old Georgetown Road, Bethesda, Maryland 20814-1729							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30082

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EARL WAYLAND KING				2. DATE OF DEATH MONTH: SEPT DAY: 23 YEAR: 1994		3. TIME OF DEATH 10:22 A	
4. SOCIAL SECURITY NUMBER 414-64-2698		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1941	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Derwood	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 17709 Millcrest Drive			
10f. ZIP CODE 20855				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed		16b. KIND OF BUSINESS/INDUSTRY Automotive Repair Service			
17. FATHER'S NAME (First, Middle, Last) Earl M. King				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cornie Combs			
19a. INFORMANT'S NAME (Type/Print) Terry J. King				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17709 Millcrest Drive Derwood, Maryland 20855			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Norbeck Memorial Park 9/27/94		20c. LOCATION — City or Town, State Olney, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy D. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter this mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Hypertensive arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W. J. Wall M.D.				29c. LICENSE NUMBER D12879		29d. DATE SIGNED (Month, Day, Year) Sept 24, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARONSO VALLE M.D., 10701 TRAFLET DR., LARGO, MD, 20772							
31. DATE FILED (Month, Day, Year) SEP 27 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30083

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Woodrow KENDLE				2. DATE OF DEATH MONTH DAY YEAR October 4, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 217-16-2815		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 15, 1924	
9a. FACILITY NAME (If not institution, give street and number) 1408 West Church Street				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1408 W. Church Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) conductor		16b. KIND OF BUSINESS/INDUSTRY railroad			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes V. Kendle			
19a. INFORMANT'S NAME (Type/Print) Lilian E. Kendle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 W. Church St., Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. View Cemetery 10-7-94		20c. LOCATION — City or Town, State Sharpsburg, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma Lung							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. H. Fleury MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) J. H. Fleury MD 12821 Cole hill avenue, Hagerstown							
31. DATE FILED (Month, Day, Year) Oct 05 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30084

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Norman Emil Keuper				2. DATE OF DEATH MONTH DAY YEAR October 3, 1994				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 508-01-2166		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 1, 1921		8. BIRTHPLACE (State or Foreign Country) Missouri			
9a. FACILITY NAME (If not Institution, give street and number) 13118 Little Antietam Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington					
10a. STATE Md.				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 13118 Little Antietam Rd.				10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? U.S.A					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Developer				15b. KIND OF BUSINESS/INDUSTRY Grocery Stores					
17. FATHER'S NAME (First, Middle, Last) Robert W. Keuper						18. MOTHER'S NAME (First, Middle, Maiden Surname) Paula E. Holtzen							
19a. INFORMANT'S NAME (Type/Print) Louise G. Keuper						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13118 Little Antietam Rd. Hagerstown, Md. 21742							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Cemetery 10-5-94				20c. LOCATION — City or Town, State Smithsburg, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis R. Davis				22. NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of prostate DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 13 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Frederick H. Kase III MD				29c. LICENSE NUMBER A2362				29d. DATE SIGNED (Month, Day, Year) 10/5/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frederick H. Kase III MD 1799 Howell Rd Hagerstown Md													
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE John B. Anderson-Russell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30085

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ERNEST TENNANT KUNZ SR.				2. DATE OF DEATH MONTH OCT DAY 05 YEAR 94		3. TIME OF DEATH 2224 P	
4. SOCIAL SECURITY NUMBER 234-30-8245		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/11/23	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
10a. STATE MARYLAND				10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION BOONSBORO	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 16834 BAKERSVILLE ROAD			
10f. ZIP CODE 21713				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROJECT MANAGER		16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) FRED ALBERT KUNZ				18. MOTHER'S NAME (First, Middle, Maiden Surname) CASSIE JANE TENNANT			
19a. INFORMANT'S NAME (Type/Print) ANNA C. KUNZ				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) POST OFFICE BOX 3, FAIRPLAY, MARYLAND 21733			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SALEM LUTHERAN CEMETERY 10/8/94		20c. LOCATION — City or Town, State BAKERSVILLE, MARYLAND		20d. DATE 10/8/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul M. Dean Paul M. Dean				22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio respiratory arrest							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. Intermittent cardiac pain							
c. Arteriosclerosis							
d. Other							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER L L Trickett MD			
29c. LICENSE NUMBER D09930				29d. DATE SIGNED (Month, Day, Year) 10/6/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L L Trickett MD 145 W. Washington Hagerstown, MD							
31. DATE FILED (Month, Day, Year) OCT 07 1994				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30086

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELEANOR FRANCIONE KILLERI				2. DATE OF DEATH MONTH DAY YEAR September 28, 1994		3. TIME OF DEATH 11:45 P.M.	
4. SOCIAL SECURITY NUMBER 177-05-1313		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 8, 1916	
9a. FACILITY NAME (If not institution, give street and number) Bedford Court Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3501 Forest Edge Drive, #14-2D				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Dennis Francione				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Bonacuse			
19a. INFORMANT'S NAME (Type/Print) Albert D. Killeri				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 N. Livingston Street, Arlington, Virginia 22205			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 9/29/94		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael S. Branson Sr.</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. chronic pancreatitis DUE TO (OR AS A CONSEQUENCE OF): b. cholelithiasis and pancreatic mass DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure coronary artery disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death 5 months months
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martha Spencer Saavedra</i>				29c. LICENSE NUMBER D41173		29d. DATE SIGNED (Month, Day, Year) 9-29-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martha Spencer Saavedra, 3701 International Dr., Silver Spring							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30087

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY KOSKORIS				2. DATE OF DEATH MONTH Sept. DAY 22 YEAR 1994		3. TIME OF DEATH 4:35 P	
4. SOCIAL SECURITY NUMBER 107-22-3092		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 8, 1929	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 23500 Ridge Road				10f. ZIP CODE 20876		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) homemaker		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) home		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Michael Simeon				16. MOTHER'S NAME (First, Middle, Maiden Surname) Assimina Bruntsos			
19a. INFORMANT'S NAME (Type/Print) Sophia Cox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15201 Birmingham Dr. Burtonsville, Md 20866			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven 9/26/94		DATE 9/26/94		20c. LOCATION — City or Town, State Silver Spring, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPOTENSION Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST OBSTRUCTIVE JAUNDICE							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MYELOPROLIFERATIVE DISEASE							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D-33224		29d. DATE SIGNED (Month, Day, Year) Sept 22, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAM TREHAN, 50W Edmonston Road #401, Rockville MD 20852							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

KATHERINE H. KNOX

94 30088

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHERINE H. KNOX				2. DATE OF DEATH MONTH SEPT. DAY 23 YEAR 94		3. TIME OF DEATH 16:45 M					
4. SOCIAL SECURITY NUMBER 047-38-4529		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 29, 1905		8. BIRTHPLACE (State or Foreign Country) Maine			
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda			9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Laytonsville			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 8301 Lando Court				10f. ZIP CODE 20882		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) Charles A. Hodgdon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne (Unknown)							
19a. INFORMANT'S NAME (Type/Print) Weldon R. Knox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10e.							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Laytonsville Cemetery		DATE 9/27		20c. LOCATION — City or Town, State Laytonsville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY Muriel H. Barber Funeral Home 20882 21525 Laytonsville Rd, Laytonsville, Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 DAYS											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 9 21 94		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED MOTOR VEHICLE ACCIDENT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MONT. VILLAGE AVE + MONTGOMERY HILL							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER DO7094		29d. DATE SIGNED (Month, Day, Year) 9-24-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK C. MYALE 1025 FERNWOOD RD BETHESDA MD 20817 1106											
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 7 9/26/94, MRT Montgomery County
Amended # 9c, 9/20/94, MRT Montgomery County
Amended # 1, 9/20/94, MRT Montgomery County

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KAUFMAN Edith Kaufman		2. DATE OF DEATH MONTH DAY YEAR 9-15-94		3. TIME OF DEATH 10 05 PM	
4. SOCIAL SECURITY NUMBER 185-32-5546		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 89 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 4-28-05		8. BIRTHPLACE (State or Foreign Country) RUSSIA			
9a. FACILITY NAME (If not institution, give street and number) Belgrad Court		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring, md		9c. COUNTY OF DEATH Montgomery	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING	
10d. INSIDE CITY LIMITS? 1 YES 2 X NO		10e. STREET AND NUMBER 3701 INTERNATIONAL DRIVE #338		10f. ZIP CODE 20906	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY SECONDARY SCHOOL	
17. FATHER'S NAME (First, Middle, Last) WILLIAM HIRSHFIELD		18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA FRANKEL			
19a. INFORMANT'S NAME (Type/Print) MAE BASSION		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7900 OLD YORK ROAD #709B-ELKINS PARK, PA. 19027			
20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, City, State) MT. COMFORT CREMATORY 9/16		20c. LOCATION - City or Town, State ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank H. Stone</i>		22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. aortic stenosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 1 year years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. emphysema peripheral vascular disease		24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 X Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 9-15-94		28b. TIME OF INJURY M 1 YES 2 NO	
28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Martha S. Saavedra MD		29c. LICENSE NUMBER D41173	
29d. DATE SIGNED (Month, Day, Year) 9-15-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTHA S. SAAVEDRA - 3701 INTERNATIONAL DRIVE - SILVER SPRING, MD. 20906			
31. DATE FILED (Month, Day, Year) SEP 20 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

94 30090

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLIFFORD Kenton				2. DATE OF DEATH MONTH September DAY 19 YEAR 94		3. TIME OF DEATH 0930 M	
4. SOCIAL SECURITY NUMBER 222-50-9481		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-4-1939	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE DEL.				10b. COUNTY SUSSEX		10c. CITY, TOWN OR LOCATION GEORGETOWN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER RD. NO. 1 BOX 1000			
10f. ZIP CODE 19947				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NEVER WORKED		16b. KIND OF BUSINESS/INDUSTRY NONE			
17. FATHER'S NAME (First, Middle, Last) CHARLES W. KENTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED JEWELL			
19a. INFORMANT'S NAME (Type/Print) LEWIS R. KENTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3175 U.S. NO. 1 SOUTH, ST. AUGUSTINE, FLA.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLLYWOOD CEMETERY DATE 9-22		20c. LOCATION — City or Town, State HARRINGTON, DEL.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ewald C. Bruner</i>				22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. metastatic Breast Cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James E. Martin, M.D.</i>				29c. LICENSE NUMBER 030690		29d. DATE SIGNED (Month, Day, Year) 9/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 145 E. Carroll St., Salisbury, MD. James E. Martin, M.D.							
31. DATE FILED (Month, Day, Year) SEP 22 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30091

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nancy Lee KEENEY				2. DATE OF DEATH MONTH October DAY 5 , YEAR 1994		3. TIME OF DEATH 11:25 PM	
4. SOCIAL SECURITY NUMBER 219-36-4689		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 8, 1940	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION New Market				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7209 Drummie Road	
10f. ZIP CODE 21774				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Assembly				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electronics		16b. KIND OF BUSINESS/INDUSTRY Electronics	
17. FATHER'S NAME (First, Middle, Last) Hugh HARGETT				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Thelma Morgan			
19a. INFORMANT'S NAME (Type/Print) Roland Luther Keeney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7209 Drummie Road, new Market, Maryland 21774			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) Rocky Hill Cemetery October 8, 1994 Woodsboro, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Draf MO0255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary hepatic failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Alcoholic hepatitis c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (1) DRUG Septicemia (2) Upper GI bleed (3) renal insufficiency bleeding DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER William O. Miller, MD			
29c. LICENSE NUMBER D14373				29d. DATE SIGNED (Month, Day, Year) 12/5/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William O. Miller, MD 804 Tall House Frederick, MD							
31. DATE FILED (Month, Day, Year) OCT 07 1994				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #7, 9/30/94, JW, Montgomery Co. 94 30092
Amended #7, 9/21/94, MRT Montgomery County

1 -
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) SADIE LEWIS		2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1994		3. TIME OF DEATH 6:05 A.M.
4. SOCIAL SECURITY NUMBER 579-42-8410	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) JUNE 14, 1918	8. BIRTHPLACE (State or Foreign Country) WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON		9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6105 MONTROSE ROAD		
10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) HOMEMAKER		
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		17. KIND OF BUSINESS/INDUSTRY OWN HOME		
18. FATHER'S NAME (First, Middle, Last) DAVID EHRlich		19. MOTHER'S NAME (First, Middle, Maiden Surname) IDA POCHOUSE		
20. INFORMANT'S NAME (Type/Print) PEARL COHEN (SISTER)		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10500 ROCKVILLE PIKE, #520 ROCKVILLE, MD 20852		
22. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) BETH SHOLOM CEMETERY		24. DATE 9/19
25. LOCATION — City or Town, State CAPITOL HEIGHTS, MD		26. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary M. Giese</i>		
27. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852				

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NON SMALL CELL CANCER OF LUNG DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval between Onset and Death
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PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			

25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Talwar, M.D.</i>	29c. LICENSE NUMBER D 36552	29d. DATE SIGNED (Month, Day, Year) SEPTEMBER 18, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. TALWAR, M.D., 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852				
31. DATE FILED (Month, Day, Year) SEP 21 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30093

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALICE BERNARD LEONARD				2. DATE OF DEATH MONTH DAY YEAR SEPT 21, 1994		3. TIME OF DEATH 11:00 P M	
4. SOCIAL SECURITY NUMBER 312.18.8161		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 11, 1921	
9a. FACILITY NAME (If not institution, give street and number) 4936 SENTINEL DRIVE APT. #103				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4936 SENTINEL DRIVE APT. # 103				10f. ZIP CODE 20816		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) FRANK B. BERNARD				18. MOTHER'S NAME (First, Middle, Maiden Surname) GLADYS JENNEY			
19a. INFORMANT'S NAME (Type/Print) CHARLES LEONARD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5808 AUGUSTA LANE BETHESDA, MD. 20816			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT		DATE 9/24		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Josh M. Boaz</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS 5130 WISCONSIN AVE. N.W. WASHINGTON D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER Approximate interval Between Onset and Death 4 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>F. Smith</i>				29c. LICENSE NUMBER AS 266 3626		29d. DATE SIGNED (Month, Day, Year) SEPT. 22, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDERICK P. SMITH M.D. 5401 WESTERN AVE. N.W. WASHINGTON D.C. 20015							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

** RELEASED TO DR. SMITH BY MEO DR. MAYLE **

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30094

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jesse L. Latham				2. DATE OF DEATH MONTH DAY YEAR October 2, 1994		3. TIME OF DEATH 11:00 A M	
4. SOCIAL SECURITY NUMBER 240-14-5044		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/5/21	
8. FACILITY NAME (If not institution, give street and number) 431 Roberts Way				9b. CITY, TOWN OR LOCATION OF DEATH Aberdeen		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 431 Roberts Way			
10f. ZIP CODE 21001				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Explosive Test Operator		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Kelly Latham				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bettie Parker			
19a. INFORMANT'S NAME (Type/Print) Virginia C. Latham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Roberts Way Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 10/5		20c. LOCATION — City or Town, State Aberdeen, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry R. Dickson</i>				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of prostate DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 1991	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles E. Eck</i> MD				29c. LICENSE NUMBER D31712		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES ECK JR 219 W. BELTHER AVE. ABERDEEN, MD							
31. DATE FILED (Month, Day, Year) OCTO 4 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30095

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Marie Lewter				2. DATE OF DEATH MONTH DAY YEAR September 20, 1994		3. TIME OF DEATH 3:12 P. M.	
4. SOCIAL SECURITY NUMBER 578-50-7108		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 2, 1914	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Adelphi		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8307 20th Ave.				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Franklin Reynolds				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Stambaugh			
19a. INFORMANT'S NAME (Type/Print) Nancy M. Waesche				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2949 Edgewater Dr. Edgewater, MD 21037			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery Sept. 23, 1994		20c. LOCATION — City or Town, State Brentwood, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. Levin</i>				22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory arrest</i> b. <i>Pulmonary embolism</i> c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 30 min
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Post-op Right middle & Lower Lobectomies for Bronchogenic Carcinoma 8 days ago</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara J. Levin</i>
29c. LICENSE NUMBER 20562							29d. DATE SIGNED (Month, Day, Year) 9/20/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARBARA J. LEVIN 10215 Fernwood Rd Bethesda, Md.							
31. DATE FILED (Month, Day, Year) SEP 27 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30096

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret Angela Linaugh</i>				2. DATE OF DEATH MONTH DAY YEAR <i>September 26 1994</i>		3. TIME OF DEATH <i>10:45 AM</i>	
4. SOCIAL SECURITY NUMBER <i>213-48-9027</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>February 28, 1906</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>9209 Glenville Road</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>9209 Glenville Road</i>				10f. ZIP CODE <i>20901</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>College</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM JOSEPH MURRAY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>NELLIE SUSAN GROVE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>PHILIP J. LINAUGH</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11848 FARMLAND DRIVE, ROCKVILLE, MARYLAND 20852</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 9/28/94</i>		20c. LOCATION — City or Town, State <i>SILVER SPRING, MARYLAND</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy G. Canbuck</i>				22. NAME AND ADDRESS OF FACILITY <i>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Dehydration</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF): <i>Dementia</i>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arrhythmia</i> <i>Hyperperfusion</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>008089</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/28/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Lebowitz, 1120 N. H. Ave., SP., MD 20904</i>							
31. DATE FILED (Month, Day, Year) <i>SEP 28 1994</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020
DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30097

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred L. Lawrence				2. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1994		3. TIME OF DEATH 6:45 A M	
4. SOCIAL SECURITY NUMBER 160-30-6443		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 4, 1915	
9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Potomac		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11616 Greenlane Drive				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Henry Curtis Croft				18. MOTHER'S NAME (First, Middle, Maiden Surname) Donna Belle Porter			
19a. INFORMANT'S NAME (Type/Print) Donna M. Umbel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green County Memorial Park 9-30		DATE 9-30		20c. LOCATION — City or Town, State Waynesburg, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Helene C Freeman				29c. LICENSE NUMBER DC 17268		29d. DATE SIGNED (Month, Day, Year) September 26, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) #312 Helene C. Freeman, M. D., 4910 Massachusetts Avenue, NW, Washington, DC 20016							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE Jill Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within four hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30098

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA James Lowry				2. DATE OF DEATH MONTH DAY YEAR September 19, 1994		3. TIME OF DEATH 2:21P M	
4. SOCIAL SECURITY NUMBER 219-14-4866		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-24-1925	
8. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland				10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 408 Pamela Dr.			
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Wildai (unk) James				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva (unk) Smith			
19a. INFORMANT'S NAME (Type/Print) Paul J. Lowry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Pamela Dr., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Allen Cemetery		DATE 9/22		20c. LOCATION — City or Town, State Allen, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.R. Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. Statin Post MI							
c. ASCVD							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald M. Wood, MD</i>		29c. LICENSE NUMBER D 10688		29d. DATE SIGNED (Month, Day, Year) 9-20-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD M. WOOD 403 QUINCEY ST. SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) SEP 22 1994		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30099

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Irving Legates				2. DATE OF DEATH MONTH DAY YEAR Sept. 18 94		3. TIME OF DEATH 1715 M	
4. SOCIAL SECURITY NUMBER 221-16-5492		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-21-28	
9a. FACILITY NAME (If not institution, give street and number) Peninsula Regional Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Delaware		10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Magnolia		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Box 82				10f. ZIP CODE 19962		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Laborer		16b. KIND OF BUSINESS/INDUSTRY Vault company	
17. FATHER'S NAME (First, Middle, Last) John Legates Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Thompson			
19a. INFORMANT'S NAME (Type/Print) Robert Legates				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D. 1, Box 173-C, Milford, DE 19963			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hollywood Cemetery		20c. LOCATION — City or Town, State Harrington, DE		20d. DATE OATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Leukemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left lower lobe pneumonia Post mitral valve replacement, 1976 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Deputy M.D.				29c. LICENSE NUMBER D03599		29d. DATE SIGNED (Month, Day, Year) 9/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D. 108 Pine Bluff Road, Salisbury, MD							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30100

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRY G. LEE				2. DATE OF DEATH MONTH DAY YEAR SEPT. 27 1994		3. TIME OF DEATH 7:16 AM	
4. SOCIAL SECURITY NUMBER 172-12-7508		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 19, 1918	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Charlotte Hall Veterans Home		9b. CITY, TOWN OR LOCATION OF DEATH Charlotte Hall	
9c. COUNTY OF DEATH St. Mary's				10a. STATE Maryland		10b. COUNTY St. Mary's	
10c. CITY, TOWN OR LOCATION Charlotte Hall				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt 2 Box 5	
10f. ZIP CODE 20622				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1940-1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Installer		16b. KIND OF BUSINESS/INDUSTRY Retail	
17. FATHER'S NAME (First, Middle, Last) James Lloyd Lee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Violet Wilson Lee			
19a. INFORMANT'S NAME (Type/Print) Mary E. Kotsol				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Delberta Rd. Lower Burrell, PA 15068			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem. 9/29		20c. LOCATION — City or Town, State Cheltenham, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hayston C. Chodura</i> M000817				22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. PERIPHERAL VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. West</i>				29c. LICENSE NUMBER D26358		29d. DATE SIGNED (Month, Day, Year) SEPT. 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN H. WEST, MD - PRINCE FREDERICK, MD - 20678							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN THOMAS LUCATAMO, SR.		2. DATE OF DEATH MONTH 09 DAY 20 YEAR 94		3. TIME OF DEATH 0400 M
4. SOCIAL SECURITY NUMBER 221-10-0549	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 12, 1911	
8. BIRTHPLACE (State or Foreign Country) Delaware				
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County		9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil
RESIDENCE OF DECEDENT				
10a. STATE Maryland	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 2816 Singerly Road		10f. ZIP CODE 21921	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Master Mechanic		16b. KIND OF BUSINESS/INDUSTRY Construction
17. FATHER'S NAME (First, Middle, Last) Alphonso Lucatamo		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Rafaela		
19a. INFORMANT'S NAME (Type/Print) John T. Lucatamo, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 277 Hollingsworth Manor, Elkton, MD 21921		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Immaculate Conception Cemetery		20c. LOCATION — City or Town, State Cherry Hill, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James S. Hicks</i>		22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF): c. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): d. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julius Davidson, M.D.</i>		29c. LICENSE NUMBER 807463	29d. DATE SIGNED (Month, Day, Year) 9-20-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rolando A. Najera, M.D. - 118 North Street, Suite 2A - Elkton, MD 21921				
31. DATE FILED (Month, Day, Year) SEP 23 '94		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30102

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise MILDRED LINTHICUM				2. DATE OF DEATH MONTH DAY YEAR Sept. 27, 1994		3. TIME OF DEATH 2230	
4. SOCIAL SECURITY NUMBER 219-03-4072		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-18-1913	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
10a. STATE Maryland				10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 517 Burton Avenue			
10f. ZIP CODE 21613				10g. CITIZEN OF WHAT COUNTRY? US			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William Dixon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Dixon			
19a. INFORMANT'S NAME (Type/Print) W. James Linthicum, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Burton Ave. Cambridge, Md. 21613			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Old Trinity Churchyard		DATE 9/30		20c. LOCATION — City or Town, State Church Creek, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Generalized Arteriosclerosis PANCREATITIS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Generalized Arteriosclerosis PANCREATITIS						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mahmood Shariff, M.D.				29c. LICENSE NUMBER D15165		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. S. SHARIFF 105 Aurora St Cambridge MD							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE 21613			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30103

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Delmas Miller Layman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Sept. 30 1994</i>		3. TIME OF DEATH <i>6:19 A M</i>	
4. SOCIAL SECURITY NUMBER <i>220-16-1151</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 17, 1913</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Frederick Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Frederick</i>		9c. COUNTY OF DEATH <i>Frederick</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Frederick</i>		10c. CITY, TOWN OR LOCATION <i>Frederick</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>909 Seminole Road</i>				10f. ZIP CODE <i>21701</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (14 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Moulder</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Iron and Steel Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Jacob Andrew Layman</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Alberta Miller</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Margaret C. Layman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>909 Seminole Rd., Frederick, Maryland 21701</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, etc.) <i>Mt. Olivet Cemetery</i>		20c. DATE <i>Oct. 3, 1994</i>		20d. LOCATION — City or Town, State <i>Frederick, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. Gaspard</i> M00021				22. NAME AND ADDRESS OF FACILITY <i>Keeney and Basford Funeral Home 106 East Church St., Frederick, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive heart failure</i> <i>Severe degenerative joint disease</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							Approximate interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ali J. Aflak</i>				29c. LICENSE NUMBER <i>D 35183</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/30/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Ali J. Aflak</i> <i>300 W 9th St, Frederick, MD</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 03 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			

TO BE COMPLETED BY FUNERAL-DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30104

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Millard Harry LINDSAY				2. DATE OF DEATH October 5, 1994		3. TIME OF DEATH 2:15 PM	
4. SOCIAL SECURITY NUMBER 214-10-2299		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 4, 1912	
9a. FACILITY NAME (If not institution, give street and number) Frederick Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4620 Urbana Pike				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder		15b. KIND OF BUSINESS/INDUSTRY Welding Company			
17. FATHER'S NAME (First, Middle, Last) Charles C. Lindsay				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie M. Hafley			
19a. INFORMANT'S NAME (Type/Print) Ethel Morgan Lindsay				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 Urbana Pike, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairmont Cemetery Oct. 8, 1994		20c. LOCATION — City or Town, State Libertytown, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. Basford</i> M00021				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Severe myocardial infarction</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>C.O.P.D.</i>					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED <i>DO 8/11</i>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert S. Hughes</i>		29c. LICENSE NUMBER D05111		29d. DATE SIGNED (Month, Day, Year) 10/6/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert S. Hughes MD 700 Montclair Ave., Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Raskett</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30105

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donald Drew Magee				2. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1994		3. TIME OF DEATH 4:00 P M	
4. SOCIAL SECURITY NUMBER 085-10-7799		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 8, 1917	
8a. FACILITY NAME (If not institution, give street and number) 14 Waterside Court				8b. CITY, TOWN OR LOCATION OF DEATH Germantown		8c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14 Waterside Court				10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Director		16b. KIND OF BUSINESS/INDUSTRY Trade Association			
17. FATHER'S NAME (First, Middle, Last) Kenneth M. Magee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Lehmann			
19a. INFORMANT'S NAME (Type/Print) Richard D. Magee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore-Washington Crem.		DATE 9-27		20c. LOCATION — City or Town, State Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Alcoholism</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D33138		29d. DATE SIGNED (Month, Day, Year) Sept. 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel A. Waller, M. D., 19511 Doctors Drive, Germantown, MD 20874							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor creases and discoloration, characteristic of old paper. Along the right edge, there are three dark circular holes, which are likely from a binding process. Faint, illegible text is visible along the top edge, possibly from the reverse side of the page or from the binding. The overall tone is a warm, off-white or light cream.

94 30106

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Elizabeth McCarthy				2. DATE OF DEATH MONTH DAY YEAR September 22, 1994				3. TIME OF DEATH 1:00 A M					
4. SOCIAL SECURITY NUMBER 578-92-2174		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 27, 1914		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 6011 Kingsford Court						9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 6011 Kingsford Court						10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Edward Fidelis Jackson						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hanlon							
19a. INFORMANT'S NAME (Type/Print) Robert J. McCarthy, M.D.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6011 Kingsford Court, Bethesda, MD 20817							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 9/26/94				20c. LOCATION — City or Town, State Arlington, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. E. Dwyer M00803						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Victor Sandor, M.D.						29c. LICENSE NUMBER DOD# 212 41 9330		29d. DATE SIGNED (Month, Day, Year) September 22, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Victor Sandor, M.D. N.N.M.C., Dept. of Oncology, Bethesda, Maryland													
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Saverio Malta				2. DATE OF DEATH MONTH 10 DAY 29 YEAR 1994		3. TIME OF DEATH 1240 p m	
4. SOCIAL SECURITY NUMBER 180-24-3375		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 24 1929	
8a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Frederick		8c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 606 Geneva Drive				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) tailor		16b. KIND OF BUSINESS/INDUSTRY men's clothing			
17. FATHER'S NAME (First, Middle, Last) Vincent (nmn) Malta				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Anna Rivero Rivero			
19a. INFORMANT'S NAME (Type/Print) Theresaa Theresa Malta				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Geneva Drive, Westminster, MD 21157			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 10/5/94 DATE Meadow Branch Cemetery		20c. LOCATION — City or Town, State Westminster, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark A. Smith				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE MYELOMA a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death 26 MONTHS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Brian M. O'Connor, MD				29c. LICENSE NUMBER 031761		29d. DATE SIGNED (Month, Day, Year) 10/2/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST. FREDERICK, MD 21701							
31. DATE FILED (Month, Day, Year) OCT 5 1994				32. REGISTRAR'S SIGNATURE Jane A. [Signature]			

94 30108

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN MOCK						2. DATE OF DEATH MONTH DAY YEAR SEPT. 23, 1994		3. TIME OF DEATH 1909 M	
4. SOCIAL SECURITY NUMBER 170-16-4862		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 6-24-21	
9a. FACILITY NAME (If not institution, give street and number) 1 IVY LANE						9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT									
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1 IVY LANE						10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) CHARLES H. YOUNG						18. MOTHER'S NAME (First, Middle, Maiden Surname) LOIS KIRK			
19a. INFORMANT'S NAME (Type/Print) LYN PAYMER						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3351 OCEAN PINES BERLIN, MD., 21811			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMETERY		20c. LOCATION — City or Town, State ARLINGTON, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 5 YRS DUE TO (OR AS A CONSEQUENCE OF):									
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RADIATION CYSTITIS CARCINOMA OF CERVIX CHRONIC OBSTRUCTIVE PULMONARY DIS									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER John H. Shenasky II MD						29c. LICENSE NUMBER D-177926		29d. DATE SIGNED (Month, Day, Year) 9/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN H. SHENASKY II MD, 106 PINE BLUFF RD, SALISBURY, MD 21801									
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30109

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Berenice McGrory				2. DATE OF DEATH MONTH DAY YEAR September 27, 1994		3. TIME OF DEATH 12:10 am	
4. SOCIAL SECURITY NUMBER 221-38-6389		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 20, 1918	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
10a. STATE Delaware		10b. COUNTY New Castle		10c. CITY, TOWN OR LOCATION Wilmington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1104 Pennsylvania Avenue				10f. ZIP CODE 19806		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Religious Teacher		16b. KIND OF BUSINESS/INDUSTRY Catholic Church			
17. FATHER'S NAME (First, Middle, Last) James McGrory				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Gallagher			
19a. INFORMANT'S NAME (Type/Print) Sister Julia Dennehy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Pennsylvania Avenue Wilmington, DE 19806			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) All Saints Cemetery		20c. LOCATION — City or Town, State Wilmington, DE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Mealey, Jr.				22. NAME AND ADDRESS OF FACILITY Mealey Funeral Home 703 North Broom Street Wilmington, DE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Eileen M. Schmitt, M.D.				29c. LICENSE NUMBER C10002045		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eileen M. Schmitt, M.D. 801 South Harrison Street Wilmington, DE 19805							
31. DATE FILED (Month, Day, Year) SEP 29 '94		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Addie Mitchell		2. DATE OF DEATH MONTH DAY YEAR Sept 29 94		3. TIME OF DEATH 430 A M
4. SOCIAL SECURITY NUMBER 214-26-7680	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1902	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County		9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil
RESIDENCE OF DECEDENT				
10a. STATE Maryland	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 269 Maloney Road		10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a		
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		17. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) John C. Chadwick		18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Garrett		
19a. INFORMANT'S NAME (Type/Print) Arthur E. Mitchell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 269 Maloney Road - Elkton, MD 21921		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Company 9-29-94		20c. LOCATION — City or Town, State West Chester, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy S. Hicks		22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CANCER OF KIDNEYS DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Julius Davidson-Pendall		29c. LICENSE NUMBER 007463
29d. DATE SIGNED (Month, Day, Year) 9-29-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rolando Najera M.D. 118 North St Elkton, Md		
31. DATE FILED (Month, Day, Year) SEP 30 '94		32. REGISTRAR'S SIGNATURE Julia Davidson-Pendall		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30111

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roger Allen Miles Sr.				2. DATE OF DEATH MONTH DAY YEAR October 9, 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 215-42-2921		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7. DATE OF BIRTH (Month, Day, Year) 12- 12- 1942				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 11410 Big Pool Road				9b. CITY, TOWN OR LOCATION OF DEATH Big Pool				9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11410 Big Pool Road				10f. ZIP CODE 21711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer		16b. KIND OF BUSINESS/INDUSTRY State Government					
17. FATHER'S NAME (First, Middle, Last) Earl J. Miles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lola Hawbaker					
19a. INFORMANT'S NAME (Type/Print) Barbara C. Miles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11410 Big Pool Road Big Pool, Maryland 21711					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery 10-12-1994		20c. LOCATION — City or Town, State Clear Spring, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery 1331 Eastern Blvd. N. Funeral Home Hagerstown, Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 15 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. McNamee M.D.</i>		29c. LICENSE NUMBER 041667		29d. DATE SIGNED (Month, Day, Year) 10.10.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael J. McNamee 1795 Howell Rd Hagerstown MD 21740									
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30112

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph Michael Miller</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>5</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1410 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>220-82-4083</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>22</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 29, 1971</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>112 S. Prospect Street</i>			
10f. ZIP CODE <i>21740</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1990 to Present</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <i>Military</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Harold Miller</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sherry Rohrer</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ellen L. Miller</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>65 Manor Drive #203 Hagerstown, Md. 21740</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery 10-8-94</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Munnick</i>				22. NAME AND ADDRESS OF FACILITY <i>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gun shot wound to head.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Suicide</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>1 second</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>10/5/94</i>		28b. TIME OF INJURY <i>0334 M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>Shot self in head</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Apartment building</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>65 Manor Drive Hagerstown MD</i>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D26806</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/5/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alfred D. H. M 747 Norton Ave Hagerstown MD 21742</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 07 1994</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30113

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine Mae MYERS				2. DATE OF DEATH MONTH DAY YEAR October 7, 1994		3. TIME OF DEATH 7:16 p. M	
4. SOCIAL SECURITY NUMBER 215-18-1756		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 8, 1918	
9a. FACILITY NAME (If not institution, give street and number) 841 West Washington Street				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 841 West Washington Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 0-6 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) supervisor of housekeeping		16b. KIND OF BUSINESS/INDUSTRY hospital			
17. FATHER'S NAME (First, Middle, Last) John Stains				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Finnyfrack			
19a. INFORMANT'S NAME (Type/Print) Mrs. Wanda Magaha				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 Washington Avenue, Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Rose Hill Cemetery		DATE 10-11-94		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Mena</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Severe Aortic Stenosis</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Anterior Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wanda Magaha</i>				29c. LICENSE NUMBER 018019		29d. DATE SIGNED (Month, Day, Year) 10-10-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30114

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOBART Mansfield MONTEE, SR.				2. DATE OF DEATH OCTOBER 02, 1994		3. TIME OF DEATH 10:00 P.	
4. SOCIAL SECURITY NUMBER 578-22-5269		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 27, 1924	
9a. FACILITY NAME (If not institution, give street and number) 13914 RIVER ROAD (RESIDENCE)				9b. CITY, TOWN OR LOCATION OF DEATH NEWBURG		9c. COUNTY OF DEATH CHARLES	
10a. STATE MD				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Newburg	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13914 River Rd.		10f. ZIP CODE 20664	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Broker				16b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Hobart C. Montee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lotta A. Murphy Montee			
19a. INFORMANT'S NAME (Type/Print) Katharine M. Montee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13914 River Rd. Newburg, MD 20664			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Ghost Cem. 10/6/1994		20c. LOCATION — City or Town, State Issue, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Echols MO0945				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. LaPlata, MD 20646			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of Pancreas b. Metastatic Liver c. Thrombophlebitis d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER George H. Wathen, MD				29c. LICENSE NUMBER D-20629		29d. DATE SIGNED (Month, Day, Year) 10/2/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE H. WATHEN, MD. PEMBROKE SQUARE, #104 WALDORF, MARYLAND 20603							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30115

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOUISE D. METZGER				2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 25, 94		3. TIME OF DEATH 0300 M	
4. SOCIAL SECURITY NUMBER 144-01-3761		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-7-99	
8. BIRTHPLACE (State or Foreign Country) N.J.				9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BERLIN	
9c. COUNTY OF DEATH WORCESTER				10a. STATE MD.			
10b. COUNTY WORCESTER				10c. CITY, TOWN OR LOCATION BERLIN			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 65 WOOD DUCK DRIVE			
10f. ZIP CODE 21811				10g. CITIZEH OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) LOUIS GOEHRY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNA HALBIG			
19a. INFORMANT'S NAME (Type/Print) DORIS LLOYD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4651A OCEAN PINES BERLIN, MD., 21811			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLLYWOOD MEMORIAL PARK		20c. LOCATION — City or Town, State UNION, N.J.		20d. DATE 10/15	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patricia Mahoney MD</i>				29c. LICENSE NUMBER D46490		29d. DATE SIGNED (Month, Day, Year) 9/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patricia Mahoney MD Atlantic General							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

110115

OFFICE OF THE SECRETARY

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94 30116

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Carlton MEEHAN				2. DATE OF DEATH MONTH DAY YEAR Sept. 25, 1994		3. TIME OF DEATH 10:45 P M	
4. SOCIAL SECURITY NUMBER 171-03-7827 A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 22, 1910	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2707 Calgary Avenue				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction		16b. KIND OF BUSINESS/INDUSTRY R. Floyd Jennings Company			
17. FATHER'S NAME (First, Middle, Last) Francis Carlton Meehan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie West			
19a. INFORMANT'S NAME (Type/Print) Mildred Meehan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Calgary Avenue Kensington, MD 20895			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery		DATE 9/28		20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas Rugow</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. myelodysplastic syndrome							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter B. Sherer MD</i>				29c. LICENSE NUMBER 021910		29d. DATE SIGNED (Month, Day, Year) 9/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter B. Sherer MD 3947 Ferrara Dr Wheaton, MD 20906							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30117

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Russell Moore				2. DATE OF DEATH MONTH September DAY 25 YEAR 1994				3. TIME OF DEATH 0953 A M					
4. SOCIAL SECURITY NUMBER 238-40-6159		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1931		8. BIRTHPLACE (State or Foreign Country) North Carolina	
9a. FACILITY NAME (If not Institution, give street and number) Shady Grove Adventist Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Darnestown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 15609 Ancient Oak Drive						10f. ZIP CODE 20878				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed				16b. KIND OF BUSINESS/INDUSTRY Cleaning Company					
17. FATHER'S NAME (First, Middle, Last) William M. Moore						18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie May Myrick							
19a. INFORMANT'S NAME (Type/Print) Mary Lou Moore						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15609 Ancient Oak Drive, Darnestown, MD 20878							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 9/29/94				20c. LOCATION — City or Town, State Rockville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theresa G. Kutta M00348						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction													
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
b. Cardiopulmonary Arrest													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER John E. Kelly						29c. LICENSE NUMBER D06349				29d. DATE SIGNED (Month, Day, Year) 9-25-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2401 Research Blvd Rockville MD 20850													
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5555-031

L.R.B.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-716 10/17/94 t.t

94 30118

Amended #1 9/28/94 MCT Montgomery County
 FOR
 1 - STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 (REG. NO.)

1. DECEDENT'S NAME (First, Middle, Last) MARINA V.		2. DATE OF DEATH MONTH DAY YEAR SEPT 25 1994		3. TIME OF DEATH 8:53A M	
4. SOCIAL SECURITY NUMBER 223-86-8833		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.	
7. DATE OF BIRTH (Month, Day, Year) June 11, 1947		8. BIRTHPLACE (State or Foreign Country) Netherlands			
9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL.		9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH MONTGOMERY.	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION North Potomac	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 13412 Bonnie Dale Drive		10f. ZIP CODE 20878		10g. CITIZEN OF WHAT COUNTRY? Netherlands	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Assistant		16b. KIND OF BUSINESS/INDUSTRY International Trading	
17. FATHER'S NAME (First, Middle, Last) Marinus Verrkart		18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Tournberg			
19a. INFORMANT'S NAME (Type/Print) William D. McLaren		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13412 Bonnie Dale Drive, North Potomac, MD 20878			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 9/28/94		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMullen Lawrence		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ACUTE AMOXAPIN INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 9-24-94		28b. TIME OF INJURY 10:40 P M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED SUBJECT INGESTED DRUG		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 13412 BONNIEDALE ROAD GAITHERSBURG, MARYLAND	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute M.D.		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) SEP 26 1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201.			
31. DATE FILED (Month, Day, Year) SEP 28 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, FORT WORTH, TEXAS 76168-0760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

94 30120

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH MILZMAN				2. DATE OF DEATH MONTH 09 DAY 24 YEAR 94		3. TIME OF DEATH 10:35P M	
4. SOCIAL SECURITY NUMBER 217-03-6740		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-20-1903	
9a. FACILITY NAME (If not institution, give street and number) NorthWest Hospital 5401 Old Court Rd. Randallstown				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Pikesville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7920 ScottsLevel Rd.				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) Seamstress		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Textile			
17. FATHER'S NAME (First, Middle, Last) Isacc Milzman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Koren Milzman			
19a. INFORMANT'S NAME (Type/Print) Pearl Shuman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3613 Ridgeway Terrace Falls Church, Virginia 22044			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Farband Cemetery 9-25-94		20c. LOCATION — City or Town, State Rosedale, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LEFT LOWER LOBE PNEUMONIA. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 CEREBROVASCULAR ACCIDENT 3 PARKINSON'S DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gregory P. Mehlis M.D.				29c. LICENSE NUMBER 041410		29d. DATE SIGNED (Month, Day, Year) 09-24-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NORTH WEST HOSPITAL RANDALLSTOWN MD 21133							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30121

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Moss				2. DATE OF DEATH MONTH DAY YEAR Sept 22 1994		3. TIME OF DEATH 5:00P M	
4. SOCIAL SECURITY NUMBER 216-22-3538		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 28 1906	
9a. FACILITY NAME (If not institution, give street and number) Meridian Health Care Center Spa Creek				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3 Murray Avenue				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher/Supervisor		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) William Hamilton Moss				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ethel Baldwin			
19a. INFORMANT'S NAME (Type/Print) Marjorie E. Wells				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 695 Americana Dr. #A-5 Annapolis, MD 21403			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 9/23/94 Brentwood, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David L. Lyster</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Hm 147 Duke of Gloucester St. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Alzheimer disease</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>Cerebral infarction</u> <u>Diabetes mellitus, type II</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles W. Kinzer</i>				29c. LICENSE NUMBER D05928		29d. DATE SIGNED (Month, Day, Year) September 23, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles W. Kinzer, M.D. 1833-A Forest Drive Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30122

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ALVIN R. MARTIN SR.				2. DATE OF DEATH MONTH DAY YEAR September 18, 1994		3. TIME OF DEATH 1800 M	
4. SOCIAL SECURITY NUMBER 222-18-1842		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-20-31	
9a. FACILITY NAME (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Delaware				10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 104 Broad Creek Rd.			
10f. ZIP CODE 19956				10g. CITIZEN OF WHAT COUNTRY? U. S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Chemical			
17. FATHER'S NAME (First, Middle, Last) Oscar P. Martin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth V. Taylor			
19a. INFORMANT'S NAME (Type/Print) Cindy Green - daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 3 Box 87D; Seaford, De. 19973			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory 9/22/94		20c. LOCATION — City or Town, State Dover, De.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Cranston</i>				22. NAME AND ADDRESS OF FACILITY Cranston Funeral Home P O Box 967; Seaford, De. 19973			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure b. Lung Cancer (small cell) c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lupus							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ignacio L. Dinardo</i>				29c. LICENSE NUMBER D5246		29d. DATE SIGNED (Month, Day, Year) 9/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ignacio L. Dinardo PRMC							
31. DATE FILED (Month, Day, Year) SEP 22 1994				32. REGISTRAR'S SIGNATURE <i>John A. Cranston</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30123

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) S. MILDRED				2. DATE OF DEATH MONTH SEPTEMBER DAY 18 YEAR 1994				3. TIME OF DEATH 7:00A M	
4. SOCIAL SECURITY NUMBER 213-38-8427		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) Aug. 4, 1920				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 186 Wood Valley Road				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) David B. McDowell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara Rogers					
19a. INFORMANT'S NAME (Type/Print) Walton R. Mason				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 Wood Valley Road - Rising Sun, MD 21911					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Friends Burial Ground		DATE 9-21-1994		20c. LOCATION — City or Town, State Calvert, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna L. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Biventricular Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Decrease ^(R) ventricular function DUE TO (OR AS A CONSEQUENCE OF): Carcinoid tumour DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 hrs 2 days									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. A. Shuman</i>				29c. LICENSE NUMBER L3530		29d. DATE SIGNED (Month, Day, Year) 9/18/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALSHUNNAR JHH									
31. DATE FILED (Month, Day, Year) SEP 23 '94				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30124

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Blanch Hilda McMillan				2. DATE OF DEATH MONTH DAY YEAR September 25 94				3. TIME OF DEATH 11:14 A.M.							
4. SOCIAL SECURITY NUMBER 246-05-9661		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 3-15-26		8. BIRTHPLACE (State or Foreign Country) North Carol-			
9a. FACILITY NAME (If not institution, give street and number) Union Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Elkton				9c. COUNTY OF DEATH Ina Cecil					
RESIDENCE OF DECEDENT															
10a. STATE Md.		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 700 A. Carters Court						10f. ZIP CODE 21903				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) m <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY at Home							
17. FATHER'S NAME (First, Middle, Last) Cosby Lyall						18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane Ayer									
19a. INFORMANT'S NAME (Type/Print) James N. McMillan						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 S. Main St., Hurlock, Md. 21643									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Mem. Pk.				DATE		20c. LOCATION — City or Town, State Elkton, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>acq. MI (myocardial infarction)</u> <u>Acvd.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jui Chih Hsu MD</i>						29c. LICENSE NUMBER D04623				29d. DATE SIGNED (Month, Day, Year) 9/26/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui Chih Hsu, MD 223 West main st. Elkton Md 21921															
31. DATE FILED (Month, Day, Year) SEP 27 '94				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30125

SHIRLEY DIANE MONTGOMERY
 1. FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Shirley Montgomery</i>				2. DATE OF DEATH MONTH <i>9</i> DAY <i>24</i> YEAR <i>94</i>		3. TIME OF DEATH <i>12:30 A</i> M	
4. SOCIAL SECURITY NUMBER <i>231-52-6182</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>50</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 21, 1943</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Laurel Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Laurel</i>	
9c. COUNTY OF DEATH <i>Prince Georges</i>				10a. STATE <i>Md.</i>		10b. COUNTY <i>Prince Georges</i>	
10c. CITY, TOWN OR LOCATION <i>Laurel</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>8708 Lindendale Dr.</i>	
10f. ZIP CODE <i>20707</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>Domestic</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Service</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Elmer Flowers</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Edith Divil</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Russell Montgomery</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8708 Lindendale Dr., Laurel, Md. 20707</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <i>Salem Cemetery</i>		20c. LOCATION — City or Town, State <i>9/27 Points, W.Va.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest C. Burner</i>				22. NAME AND ADDRESS OF FACILITY <i>Burner Trade Services 1037 Dual Pl. Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>coronary artery disease</i> <i>systemic lupus erythematosus</i> <i>hypertension</i> <i>diabetes</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Angina pectoris</i> <i>hypertension</i> <i>diabetes</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Sanders-Randall</i>				29c. LICENSE NUMBER <i>501499</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/24/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>SEP 27 1994</i>				32. REGISTRAR'S SIGNATURE <i>John D. Sanders-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30126

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Harold McDevitt</i>				2. DATE OF DEATH MONTH DAY YEAR Sept. 30 1994				3. TIME OF DEATH 6:35 a m					
4. SOCIAL SECURITY NUMBER 192-26-4926		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18 1903		8. BIRTHPLACE (State or Foreign Country) PA			
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 8911 N. Westland Drive				10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Bookkeeper				16b. KIND OF BUSINESS/INDUSTRY Coal Industry					
17. FATHER'S NAME (First, Middle, Last) Robert Glass				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katie Cleary									
19a. INFORMANT'S NAME (Type/Print) David T. McDevitt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8911 N. Westland Dr. Gaithersburg, Md. 20877									
20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross 10/5 Yeadon, PA				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. C. Hitt</i>				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, Md. 20838									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Carcinoma of Breast</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 1 Day 2 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Carcinoma of Stomach</i>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Smith MD</i>				29c. LICENSE NUMBER 07162 MD				29d. DATE SIGNED (Month, Day, Year) 9/30/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1500 Sully Grove Rd Rockville Md 20850													
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

94 30127

ITEMS: 28a-f, PER. MEO FILM G-717 11/14/94 t.t

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LESLIE ANNE NOTTINGHAM				2. DATE OF DEATH MONTH DAY YEAR SEPT 26 94		3. TIME OF DEATH 5:45 p.m.	
4. SOCIAL SECURITY NUMBER 217-04-1451		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 26, 1965	
9a. FACILITY NAME (If not institution, give street and number) 7505 NEED WOOD ROAD				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH MONTGOMERY COUNTY	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 13 Dale Drive				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY School			
17. FATHER'S NAME (First, Middle, Last) William P. Nottingham, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara A. Bonner			
19a. INFORMANT'S NAME (Type/Print) Barbara A. Nottingham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Dale Drive, Rockville, Maryland 20850			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 9/30/94		20c. LOCATION — City or Town, State Bethesda, Maryland		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David E. Perry</i> M00803				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Intestinal gunshot wound</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 9/26/94		28b. TIME OF INJURY 4:20 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOUSE		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT SELF					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7505 NEEDWOOD ROAD DARWOOD, MARYLAND							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) SEPT 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3, 4, 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30128

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCIS W. NULL				2. DATE OF DEATH MONTH DAY YEAR 10 01 94		3. TIME OF DEATH 3:13 P M	
4. SOCIAL SECURITY NUMBER 709-10-6584		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-08-12	
8. BIRTHPLACE (State or Foreign Country) Fostoria, Ohio				9a. FACILITY NAME (If not institution, give street and number) 4910 Baptist Road		9b. CITY, TOWN OR LOCATION OF DEATH Taneytown	
9c. COUNTY OF DEATH Carroll County				10a. STATE Maryland		10b. COUNTY Carroll County	
10c. CITY, TOWN OR LOCATION Taneytown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4910 Baptist Road	
10f. ZIP CODE 21787		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrical Engineer	
16b. KIND OF BUSINESS/INDUSTRY Utility Co.		17. FATHER'S NAME (First, Middle, Last) ThurLOW W. Null		18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Belle Witherow		19a. INFORMANT'S NAME (Type/Print) Betty MacPherson Null	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4910 Baptist Road Taneytown, Maryland 21787		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity UCC Cemetery		20c. LOCATION — City or Town, State Taneytown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Clarence E. Wilson</i>		22. NAME AND ADDRESS OF FACILITY CLARENCE E. WILSON 25 East Main Street Fairfield, Pennsylvania 17320		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carolyn F. Claxton MD</i>		29c. LICENSE NUMBER MD0045478L		29d. DATE SIGNED (Month, Day, Year) ► 10-3-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20 E High St. Gettysburg PA 17325		31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30129

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Shirley Ann Ohnmeiss				2. DATE OF DEATH MONTH 09 DAY 22 YEAR 94				3. TIME OF DEATH 7:30 P.M.	
4. SOCIAL SECURITY NUMBER 198-30-1631		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Feb. 13, 1937	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland				10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Joppa				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1512 Old Joppa Road	
10f. ZIP CODE 21085				10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY ---	
17. FATHER'S NAME (First, Middle, Last) David (nmn) Tracey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Mae Bonner				19a. INFORMANT'S NAME (Type/Print) Christina M. Taylor	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Laburnum Road, Edgewood, Md. 21040				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Angel Hill Cemetery 9/25/94	
20c. LOCATION — City or Town, State Havre de Grace, Md.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. HEPATIC ENCEPHALOPATHY b. BLEEDING DUODENAL ULCER c. URINARY TRACT INFECTION d. ALCOHOLIC LIVER DISEASE								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard K. McComas III</i>				29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year)				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year) SEP 26 1994	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30130

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA LUIZA OZORIO DE ALMEIDA				2. DATE OF DEATH MONTH DAY YEAR 07 25 94		3. TIME OF DEATH 10:30 A.M.	
4. SOCIAL SECURITY NUMBER 627-32-1802		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 12, 1944	
8. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		10. COUNTY OF DEATH	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 6651 Fairfax Road				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? Brazil	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Brazilian		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 6		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Economist		17. KIND OF BUSINESS/INDUSTRY World Bank			
18. FATHER'S NAME (First, Middle, Last) Miguel Ozorio de Almeida				19. MOTHER'S NAME (First, Middle, Maiden Surname) Zelia Seabra			
20. INFORMANT'S NAME (Type/Print) Monica Hirst				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guayra 1688, Buenos Aires, Argentina 1429			
22. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		24. DATE 9-27		25. LOCATION — City or Town, State Silver Spring, Maryland	
26. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				27. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CYTOMEGALOVIRUS INFECTION (hepatitis + colitis) 2 months					
		b. GRAFT VS HOST DISEASE 2 months					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. MULTIPLE MYELOMA					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
29. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				30. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		31. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
32. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		33. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
34. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		35. DATE OF INJURY (Month, Day, Year)		36. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		37. DESCRIBE NOW INJURY OCCURRED	
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		39. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
40. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
41. SIGNATURE AND TITLE OF CERTIFIER Hayden G. Braine MD				42. LICENSE NUMBER 67555		43. DATE SIGNED (Month, Day, Year) 9/25/94	
44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. WOLFE STREET BALTIMORE, MD 21287							
45. DATE FILED (Month, Day, Year) SEP 27 1994		46. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30131

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Priscilla M. Oesch				2. DATE OF DEATH MONTH DAY YEAR Sept. 27, 1994		3. TIME OF DEATH 10:15 PM	
4. SOCIAL SECURITY NUMBER 270-20-0803		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 14, 1920	
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) Fernwood House		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10. RESIDENCE OF DECEDENT			
10a. STATE Ohio		10b. COUNTY Mahoning		10c. CITY, TOWN OR LOCATION Boardman		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 818 Kentwood Drive, #2				10f. ZIP CODE 44512		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) — 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Francis H. McCormick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Lombard			
19a. INFORMANT'S NAME (Type/Print) James R. Oesch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Ridge Road, Annandale, Virginia 22003			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Tod Cemetery 10/3/94		20c. LOCATION — City or Town, State Youngstown, Ohio		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Metastatic Breast Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Davidson-Randall</i>				29c. LICENSE NUMBER D31319		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herato S. Alzola, MD 8218 Wisconsin Ave Bethesda MD.							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30132

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARJORIE POWERS				2. DATE OF DEATH MONTH SEPT. DAY 26 YEAR 1994		3. TIME OF DEATH 4:54 P.M.	
4. SOCIAL SECURITY NUMBER 535.38.7877		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 26, 1908	
9a. FACILITY NAME (If not Institution, give street and number) CARRIAGE HILL BETHESDA				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION POTOMAC		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9317 MERCY HOLLOW LANE				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REALTOR		16b. KIND OF BUSINESS/INDUSTRY REAL ESTATE			
17. FATHER'S NAME (First, Middle, Last) HUGH HOUSE DILS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY CURTIS			
19a. INFORMANT'S NAME (Type/Print) HARRY CAIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9317 MERCY HOLLOW LANE POTOMAC, MD. 20854			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT		DATE 9/27		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Peters</i>				22. NAME AND ADDRESS OF FACILITY JOS GAWLERS SONS INC. 5130 WISC. AVE NW WASHINGTON, D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George W. Graves MD</i>				29c. LICENSE NUMBER D29353		29d. DATE SIGNED (Month, Day, Year) SEPT. 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE W. GRAVES M.D. 5530 WISCONSIN AVE CHEVY CHASE, MARYLAND 20815							
31. DATE (Month, Day, Year) SEP 30 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30133

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John R. Perry				2. DATE OF DEATH MONTH DAY YEAR Sept. 29 1994		3. TIME OF DEATH 10:30 p.m.^M	
4. SOCIAL SECURITY NUMBER 220-01-8991		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06/10/08	
9a. FACILITY NAME (If not institution, give street and number) Charles County Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH LaPlata, Maryland		9c. COUNTY OF DEATH Charles	
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION La Plata		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Route 488				10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Powerline Technician		16b. KIND OF BUSINESS/INDUSTRY US Government			
17. FATHER'S NAME (First, Middle, Last) William Benjamin Perry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ursula Gibbons			
19a. INFORMANT'S NAME (Type/Print) Carole Ann Perry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 Wisconsin Avenue NW, Washington DC 20016			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Joseph's Cemetery		20c. LOCATION — City or Town, State Pomfret, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark G. Brohawn</i> Mark G. Brohawn M00053		22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Isolate cancer</i> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema, Anemia, Spleen disorder</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul E. Pritchett</i> Paul E. Pritchett, SR MD, F.A.A.P.		29c. LICENSE NUMBER D08370		29d. DATE SIGNED (Month, Day, Year) 9/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul E. Pritchett, SR MD, F.A.A.P. P.O. Box 1317 LaPlata, Maryland 20646							
31. DATE FILED (Month, Day, Year) OCT 04 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30134

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTIN HENRY PESKOFF				2. DATE OF DEATH MONTH 9 DAY 30 YEAR 94		3. TIME OF DEATH 2:14P	
4. SOCIAL SECURITY NUMBER 212-30-7108		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun 6, 1933	
9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Hampstead		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4426 Black Rock Road				10f. ZIP CODE 21074		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY City of Baltimore			
17. FATHER'S NAME (First, Middle, Last) Alter Peskoff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Bernitt			
19a. INFORMANT'S NAME (Type/Print) Evelyn Heird				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Oakdale Dr, Hampstead, MD 21074			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem Park		DATE 10/3		20c. LOCATION — City or Town, State Sykesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BRAIN STEM STROKE DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED 				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin Magram MD</i>				29c. LICENSE NUMBER 		29d. DATE SIGNED (Month, Day, Year) 	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN MAGRAM MD 3611 GARDENVIEW ROAD BAIT, MD. 21208							
31. DATE FILED (Month, Day, Year) OCT - 4 1994				32. REGISTRAR'S SIGNATURE <i>William Carroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.


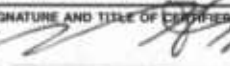
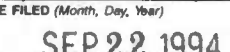
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <div style="text-align: center; font-size: 1.2em;">JEWELL silvia POBST</div>		2. DATE OF DEATH MONTH DAY YEAR <div style="text-align: center; font-size: 1.2em;">Sept. 17, 1994</div>		3. TIME OF DEATH <div style="text-align: center; font-size: 1.2em;">5:50 P M</div>	
4. SOCIAL SECURITY NUMBER <div style="font-size: 1.2em;">474-18-3539</div>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <div style="font-size: 1.2em;">76</div>	
		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & REHAB CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT		10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10e. STREET AND NUMBER 208 Tilghman St.		10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	
Elementary/Secondary (0-12) 12		College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY Retail	
17. FATHER'S NAME (First, Middle, Last) Severt Ole Tang		18. MOTHER'S NAME (First, Middle, Maiden Surname) Jenny Ronning			
19a. INFORMANT'S NAME (Type/Print) Warren Pobst		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Fiechtner Dr., Fargo, ND 58103			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens 9/21		20c. LOCATION — City or Town, State Hebron, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden death		b. Due to (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Black cerebral infarct			
		d. Due to (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 029349	
29d. DATE SIGNED (Month, Day, Year) 9/9/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801			
31. DATE FILED (Month, Day, Year) SEP 22 1994		32. REGISTRAR'S SIGNATURE 			

17 90132

THE AMERICAN MEDICAL ASSOCIATION

1100 North Dearborn Street, Chicago, Ill. 60610

1100 North Dearborn Street, Chicago, Ill. 60610

1100 North Dearborn Street, Chicago, Ill. 60610

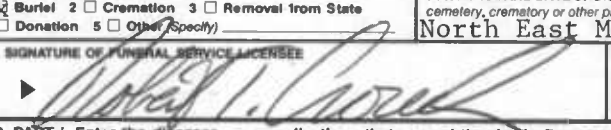

SEP 23 1961

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94 30136

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Paul				2. DATE OF DEATH MONTH DAY YEAR Sept 19 1994		3. TIME OF DEATH 5:57 P M	
4. SOCIAL SECURITY NUMBER none		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 10		7. DATE OF BIRTH (Month, Day, Year) Sept. 9, 1994	
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland		9c. COUNTY OF DEATH Baltimore City	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Northeast Maryland		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 290 Stevenson Road				10f. ZIP CODE 21901		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Not applicable		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) Jerry Donaldson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Theresa Paul			
19a. INFORMANT'S NAME (Type/Print) MARY T. PAUL Medical Record				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 290 Stevenson Road, Northeast, Md 21901			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) North East Methodist Cem. 9/23/94 North East, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cytomegalovirus encephalitis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure, Disseminated intravascular Coagulopathy, Hepatitis						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lillian R. Blackmon M.D.				29c. LICENSE NUMBER MD 26066		29d. DATE SIGNED (Month, Day, Year) Sept. 19, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lillian R. Blackmon, M.D.							
31. DATE FILED (Month, Day, Year) SEP 26 '94		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0026

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PLATE 11

9

22

94 30137

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas E. Phillips				2. DATE OF DEATH MONTH DAY YEAR 09 23 94		3. TIME OF DEATH 9:30 a.m.	
4. SOCIAL SECURITY NUMBER 220-26-3304		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 3, 1926	
9a. FACILITY NAME (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE		9c. COUNTY OF DEATH DORCHESTER	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY DORCHESTER		10c. CITY, TOWN OR LOCATION EAST NEW MARKET		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5715 EAST NEW MARKET-MT. HOLLY ROAD				10f. ZIP CODE 21631		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER		16b. KIND OF BUSINESS/INDUSTRY AGRICULTURE	
17. FATHER'S NAME (First, Middle, Last) THOMAS LEONARD PHILLIPS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA McNAMARA			
19a. INFORMANT'S NAME (Type/Print) HELEN V. KIRBY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 KILLARNEY ROAD, CAMBRIDGE, MD 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) EAST NEW MARKET CEM.		20c. LOCATION — City or Town, State 9/27 EAST NEW MARKET, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leonard O. Zeller</i>				22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET, MD 21631			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Prostate cancer</i> Prostate Cancer				Approximate interval between Onset and Death 4 years	
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rosemary Harris</i>				29c. LICENSE NUMBER D-43707		29d. DATE SIGNED (Month, Day, Year) 9/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rosemary Harris 408 Byrn Street Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) SEP 30 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30138

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carl Robert Piepoli				2. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1994		3. TIME OF DEATH 12:35 P M	
4. SOCIAL SECURITY NUMBER 215-22-7954		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1920 October 30,	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 111 W. 14th Street				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Micro-Biologist		15b. KIND OF BUSINESS/INDUSTRY Biology/Research			
17. FATHER'S NAME (First, Middle, Last) Vito Piepoli				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Martucci			
19a. INFORMANT'S NAME (Type/Print) Helen M. Piepoli				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 W. 14th Street, Frederick, MD 21701			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Mem. Gar. Crematory 9/27/94		20c. LOCATION — City or Town, State Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kyan M. Bergen</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrhythmia</i> b. <i>Hypertension</i> c. <i>Hyperkalemia</i> d. <i>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</i>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard A. Yeron, MD</i>				29c. LICENSE NUMBER D41717		29d. DATE SIGNED (Month, Day, Year) 9/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 56 THOMAS JOHNSON DRIVE FREDERICK, MD 21702							
31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30139

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) CHARLES FREDERICK PFEIFFER				2. DATE OF DEATH MONTH DAY YEAR October 2, 1994		3. TIME OF DEATH 0055 A M	
4. SOCIAL SECURITY NUMBER 224-52-4811		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 13, 1918	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Meyersville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11308-A Highland School Rd.	
10f. ZIP CODE 21773				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military / Government		16b. KIND OF BUSINESS/INDUSTRY U.S. Military	
17. FATHER'S NAME (First, Middle, Last) Frederick Ludwig Pfeiffer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Mahoney			
19a. INFORMANT'S NAME (Type/Print) Delores F. Pfeiffer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11308-A Highland School Rd. / Meyersville, Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 10/4/94		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Aneurysm							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael S Rudman</i>				29c. LICENSE NUMBER D17601		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael Behre, M.D. 5 Church & Franklin Street Middletown, MD 21769							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30140

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

OHMH-16 Rev 1/89

94 30141

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARVIN HARRY Richard				2. DATE OF DEATH MONTH 9 DAY 23 YEAR 94		3. TIME OF DEATH 4:35 P.M.	
4. SOCIAL SECURITY NUMBER 205-16-5353		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/23/23	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2106 Browns Ct.			
10f. ZIP CODE 21040				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNK College (1-4 or 5+) UNK		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Farmer			
17. FATHER'S NAME (First, Middle, Last) UNK				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNK			
19a. INFORMANT'S NAME (Type/Print) Mr. Donald R. Walker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Dewberry Way Bel Air, Maryland 21014			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) holly Hill Cemetery		DATE 9/26		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kenneth B. Borge				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis, intraabdominal Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Emphysema, severe c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Andrew Nowakowski MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 9/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW NOWAKOWSKI MD 127 N. MAIN ST. BALTIMORE MD 21201							
31. DATE (Month, Day, Year) SEP 23 1994		32. REGISTRAR'S SIGNATURE Jana Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <i>Bernard Rye</i> Bernard Francis Rye			2. DATE OF DEATH MONTH DAY YEAR September 22, 1994		3. TIME OF DEATH 9 48 P.M.	
4. SOCIAL SECURITY NUMBER 218-10-7106		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		
7a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		7b. CITY, TOWN OR LOCATION OF DEATH Olney		7c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Damascus		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8604 Gue Road		10f. ZIP CODE 20872		
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bricklayer Foreman		16b. KIND OF BUSINESS/INDUSTRY Construction		17. FATHER'S NAME (First, Middle, Last) Robert Rye		
18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Sullivan		19a. INFORMANT'S NAME (Type/Print) Mabel L. Rye		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 Gue Road Damascus, Maryland 20872		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Burtonsville Union Cemetery 9/26/94		20c. LOCATION — City or Town, State Burtonsville, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy G. Campbell</i>		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Cardioembolic Shock</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Previous stroke</i>					Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Gold</i>		29c. LICENSE NUMBER 29300		29d. DATE SIGNED (Month, Day, Year) 9/22/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Gold, M.D. 15225 Shady Grove Road Rockville, Maryland 20850-3259						
31. DATE FILED (Month, Day, Year) SEP 27 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



14



94 30143

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA L. RUSH				2. DATE OF DEATH MONTH DAY YEAR 9-21-94		3. TIME OF DEATH 2:45 P. M.	
4. SOCIAL SECURITY NUMBER 221-07-2336		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) 6-27-1915		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) 306 Pineway				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
10a. STATE Md.		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 306 Pineway				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9 Elementary/Secondary (9-12) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		15b. KIND OF BUSINESS/INDUSTRY Garment Co.			
17. FATHER'S NAME (First, Middle, Last) Marion Thomas Adkins				16. MOTHER'S NAME (First, Middle, Maiden Surname) Elva Mae Layfield Adkins			
19a. INFORMANT'S NAME (Type/Print) Eleanor L. Elliott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt#1 Box 434A Delmar, De. 19940			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens 9-24		20c. LOCATION — City or Town, State Hebron, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC Squamous cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. Cigarette use DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death 2 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ma MD</i>				29c. LICENSE NUMBER D39813		29d. DATE SIGNED (Month, Day, Year) 9/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Adkins 1104 Healthways Ave Salisbury MD 21801							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30144

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STELLA MAY REYNOLDS				2. DATE OF DEATH MONTH DAY YEAR 9/ 19/ 1994		3. TIME OF DEATH 10:30 P. M.	
4. SOCIAL SECURITY NUMBER 219-28-3445		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul 20 1908	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore City	
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Port Deposit		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 180 Funk Rd				10f. ZIP CODE 21904		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Clarence W McCall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura May Wiggins			
19a. INFORMANT'S NAME (Type/Print) Edward I Pierce				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Funk Rd Port Deposit MD 21904			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) West Nottingham Sept 22 1994		20c. LOCATION — City or Town, State Colora MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Jooke</i>				22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COLOON CA with mets DUE TO (OR AS A CONSEQUENCE OF): a. COLOON CA with mets b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eddie Nakhuda</i>				29c. LICENSE NUMBER 15204		29d. DATE SIGNED (Month, Day, Year) 9/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) SEP 21 '94				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30145

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHARON L. RICHARDS				2. DATE OF DEATH MONTH OCTOBER DAY 1 YEAR 1994				3. TIME OF DEATH 09:49A M	
4. SOCIAL SECURITY NUMBER 191-48-2812		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 13, 1957		8. BIRTHPLACE (State or Foreign Country) Penna.	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Penna		10b. COUNTY York		10c. CITY, TOWN OR LOCATION Hanover				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 46 Colonial Crest Circle				10f. ZIP CODE 17331		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE - American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or S+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Paste up artist			16b. KIND OF BUSINESS/INDUSTRY Publishing		
17. FATHER'S NAME (First, Middle, Last) Charles Greesey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Frye					
19a. INFORMANT'S NAME (Type/Print) Steven M. Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Colonial Crest Cr. Hanover Pa. 17331					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Inc 10/27/94			20c. LOCATION - City or Town, State Hampstead Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen K. Muller				22. NAME AND ADDRESS OF FACILITY Wetzel Funeral Home Hanover Pa					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Liver failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Liver failure DUE TO (OR AS A CONSEQUENCE OF): 3 years b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): 2 days c. Coagulopathy DUE TO (OR AS A CONSEQUENCE OF): 3 days d. Anemia DUE TO (OR AS A CONSEQUENCE OF): 3 days									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Mark Lewis M.D.				29c. LICENSE NUMBER M6321			29d. DATE SIGNED (Month, Day, Year) 10/1/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Lewis M.D. 110 Tower Johns Hopkins Hosp. Balto Md									
31. DATE FILED (Month, Day, Year) OCT 07 1994				32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30146

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lena Catherine RAY				2. DATE OF DEATH MONTH September 27, DAY 1994 YEAR				3. TIME OF DEATH 11:15 PM	
4. SOCIAL SECURITY NUMBER 214-10-2138		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 15, 1912		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1623 Shookstown Road				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY Dry Cleaners		
17. FATHER'S NAME (First, Middle, Last) Roger S. QUINN				16. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie B. SCHILDT					
19a. INFORMANT'S NAME (Type/Print) Robert T. Whitmore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Shookstown Road, Frederick, Maryland 21702					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frederick Memorial Park, September 30, 1994 Frederick, Maryland			20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Hyl MOO255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Thromboses with left hemiplegia Gastro-Intestinal bleeding Diabetes									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Bernard O. Thomas, Jr.				29c. LICENSE NUMBER D13409		29d. DATE SIGNED (Month, Day, Year) 9/29/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Bernard O. Thomas, Jr., MD 1900 Rosemont Avenue, Frederick, Maryland 21702									
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE John Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30147

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILTON SMITH, JR.				2. DATE OF DEATH MONTH 09 DAY 23 YEAR 94		3. TIME OF DEATH 9:20am	
4. SOCIAL SECURITY NUMBER 214-66-8285		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/10/54	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Lanham	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 7221 Cipriano Spring Drive			
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 1/2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Milton Smith, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Bernice Thomas			
19a. INFORMANT'S NAME (Type/Print) Lillian B. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21617 P.O. Box 14, 109 Spainands Neck Rd. Centreville, MD			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesterfield Cemetery		DATE 9/29		20c. LOCATION — City or Town, State Centreville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry B. Stohr</i>				22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Wash. D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Acquired Immune Deficiency Syndrome yrs. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 10 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret S. Chao</i>				29c. LICENSE NUMBER D17197		29d. DATE SIGNED (Month, Day, Year) 9-23-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret S. Chao, MD 7610 Carroll Ave #360 Takoma Park, MD 20912							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9

Small white

94 30148

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nathan K. Solomon				2. DATE OF DEATH MONTH 9 DAY 22 YEAR 94		3. TIME OF DEATH 1:20 am	
4. SOCIAL SECURITY NUMBER 550-96-8671		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 8, 1924	
8. BIRTHPLACE (State or Foreign Country) Burma				9. FACILITY NAME (If not institution, give street and number) Church Hospital			
10a. STATE Maryland				10b. COUNTY Baltimore			
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1 West Conway Street #505				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16. KIND OF BUSINESS/INDUSTRY Self-employed			
17. FATHER'S NAME (First, Middle, Last) T. M. Kanakasabai				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jagawamy (Unavailable)			
19a. INFORMANT'S NAME (Type/Print) Sukumar Kanagasabai Paul				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9763 Hellingly Place, Gaithersburg, MD 20879			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore-Washington Crematory 9-22		20c. LOCATION — City or Town, State Laurel, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] MD0827	
22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A.		22. NAME AND ADDRESS OF FACILITY 933 Gist Ave, Silver Spring, MD 20910		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple organ failure syndrome DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis syndrome DUE TO (OR AS A CONSEQUENCE OF): c. pneumonia DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. @ Coronary Artery Disease @ Chronic Renal Failure				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] M.D.				29c. LICENSE NUMBER D38882		29d. DATE SIGNED (Month, Day, Year) 9/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KHALID R. AL-TALIB, Church Home Hospital, Baltimore MD							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



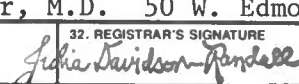
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30149

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna				2. DATE OF DEATH MONTH DAY YEAR Sept. 27, 1994				3. TIME OF DEATH 1:05 P. M			
4. SOCIAL SECURITY NUMBER 164-10-2741		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1909		8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville			9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5910 Granby Road				10f. ZIP CODE 20855		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker			16b. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) Francis Bradley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Jordan							
19a. INFORMANT'S NAME (Type/Print) Joseph F. Stockel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Denis Cemetery		DATE 10/1		20c. LOCATION — City or Town, State Havertown, Pennsylvania					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Polymyositis DUE TO (OR AS A CONSEQUENCE OF): d. Pseudomembranous colitis Approximate Interval Between Onset and Death 2 weeks 5 years 5 years 1 month								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Blindness DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 35792		29d. DATE SIGNED (Month, Day, Year) Sept. 27, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Swaroop Sudhakar, M.D. 50 W. Edmonston Dr. #504 Rockville, Maryland 20852											
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5588-031

DWG

94 30150

Amended #1, 9/30/94, JW, Montgomery Co.

FOR
#18
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STEVEN W. SKIVER <i>Steven Wayne Skiver</i>				2. DATE OF DEATH MONTH DAY YEAR SEPT. 27 94		3. TIME OF DEATH M 7:20P	
4. SOCIAL SECURITY NUMBER 217-08-5284		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 23 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 5, 1970	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3524 SINGERS GLEN DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 14007 Cove Lane Apt. #104	
10f. ZIP CODE 20851				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Builder/Renovation	
17. FATHER'S NAME (First, Middle, Last) Malcolm Wayne Skiver				18. MOTHER'S NAME (First, Middle, Maiden Surname) M. Barbara Ann Seawright			
19a. INFORMANT'S NAME (Type/Print) Malcolm W. Skiver				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Veirs Mill Road, Rockville, MD 20851			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/2/94		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hanging Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) UNK		28b. TIME OF INJURY UNK M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED Subject hanged self		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME, GARAGE	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3524 Singers Glen Dr.				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) SEPT. 28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John W. Locke, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30151

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Maud Harden Seavey				2. DATE OF DEATH MONTH DAY YEAR Oct 1, 1994				3. TIME OF DEATH 11:05 P M			
4. SOCIAL SECURITY NUMBER 215-32-2412				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH MONTH DAY YEAR Jul 1, 1901		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Westminster Nurs & Conval Ctr						9b. CITY, TOWN OR LOCATION OF DEATH Westminster			9c. COUNTY OF DEATH Carroll		
RESIDENCE OF DECEASED											
10a. STATE Maryland			10b. COUNTY Carroll			10c. CITY, TOWN OR LOCATION Hampstead			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 605 Lees Mill Road						10f. ZIP CODE 21074			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed				16b. KIND OF BUSINESS/INDUSTRY Seamstress			
17. FATHER'S NAME (First, Middle, Last) Benjamin F. Beck						18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Emory					
19a. INFORMANT'S NAME (Type/Print) J. Lynn Williams						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Weaver Lane, Hampstead, MD 21074					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 10/5				20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven W. Eline						22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. atherosclerosis DUE TO (OR AS A CONSEQUENCE OF):											
c. ASCVD DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER John M. ...						29c. LICENSE NUMBER D25443		29d. DATE SIGNED (Month, Day, Year) 10/3/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1130 Baltimore Blvd Westminster, Md 21157											
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE John ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30152

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bessie May Szamborski				2. DATE OF DEATH MONTH October DAY 2 YEAR 94		3. TIME OF DEATH 1522 M	
4. SOCIAL SECURITY NUMBER 528-56-2297		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 14 1928	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 305 Porter Rd				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Housekeeping			
17. FATHER'S NAME (First, Middle, Last) Amos May				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wanie Unknown			
19a. INFORMANT'S NAME (Type/Print) Marilyn Boldin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Honeysuckle Dr Port Deposit MD 21904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Brookview Cemetery Oct 5 1994		20c. LOCATION — City or Town, State Rising Sun, MD		20d. DATE Oct 5 1994	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Goodie</i>				22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest / Acute Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. End-stage COPD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Rudani-Ryan M.D.</i>				29c. LICENSE NUMBER D4646-7		29d. DATE SIGNED (Month, Day, Year) Oct 3, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Leila KIRDANI-M.D. 111 W. High St, Elkton, Md							
31. DATE FILED (Month, Day, Year) OCT 04 '94				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30153

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIOLA REBECCA SCOTT				2. DATE OF DEATH MONTH OCTOBER DAY 8 YEAR 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-16-1711		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
9a. FACILITY NAME (If not institution, give street and number) 20 1/2 BELVIEW AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN				9c. COUNTY OF DEATH WASHINGTON	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 20 1/2 BELVIEW AVENUE				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PARTS HANDLER				16b. KIND OF BUSINESS/INDUSTRY FURNITURE MANUFACTURER	
17. FATHER'S NAME (First, Middle, Last) NOAH FRANCIS HENSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA ELLEN RIPPLE					
19a. INFORMANT'S NAME (Type/Print) ELLEN L. SCOTT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 DEWEY AVENUE, HAGERSTOWN, MARYLAND 21742					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR LAWN MEMORIAL PARK 10-11-94 HAGERSTOWN, WASH., MD.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Noel Brady</i>				22. NAME AND ADDRESS OF FACILITY ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM STREET, HAGERSTOWN, MD. 21740					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Colon Cancer Terminal</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i>								Approximate interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francisco L. Andrade</i>				29c. LICENSE NUMBER 027898				29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN, MD 21740									
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE <i>John Harrison-Rudolph</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30154

FOR
STATE
REGISTRAR **Laura Jane Stuart** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Laura Stuart				2. DATE OF DEATH MONTH 10 DAY 9 YEAR 94		3. TIME OF DEATH 4:20 P. M.										
4. SOCIAL SECURITY NUMBER 459-60-4828		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 1, 1904										
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery										
RESIDENCE OF DECEDENT																
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
10e. STREET AND NUMBER 18631 Crestwood Drive				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA										
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White										
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY home												
17. FATHER'S NAME (First, Middle, Last) William Henry Ramsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Flora Belle Miller												
19a. INFORMANT'S NAME (Type/Print) Locke M. Stuart, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8401 Cathedral Avenue New Carrollton, Maryland 20784												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery		DATE 10/13		20c. LOCATION — City or Town, State Hagerstown, Maryland										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gerald N. Minnich				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiogenic Shock. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 wk.</td> </tr> <tr> <td>b.</td> <td>Left Ventricular Dysfunction (progressive) 2 yrs.</td> </tr> <tr> <td>c.</td> <td>Ischemic Cardiomyopathy</td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> </table>								a.	DUE TO (OR AS A CONSEQUENCE OF):	Approximate Interval Between Onset and Death 1 wk.	b.	Left Ventricular Dysfunction (progressive) 2 yrs.	c.	Ischemic Cardiomyopathy	d.	DUE TO (OR AS A CONSEQUENCE OF):
a.	DUE TO (OR AS A CONSEQUENCE OF):	Approximate Interval Between Onset and Death 1 wk.														
b.	Left Ventricular Dysfunction (progressive) 2 yrs.															
c.	Ischemic Cardiomyopathy															
d.	DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation, Hypothyroidism, Depression						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)												
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. SIGNATURE AND TITLE OF CERTIFIER Stuart Turkentz, M.D.				29c. LICENSE NUMBER D 31001		29d. DATE SIGNED (Month, Day, Year) 10/10/94										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart Turkentz, M.D. 2500 Greenway Ctr. Dr. #430 Greenbelt, Md. 20770.																
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE Laura Jane Stuart												

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30155

FOR
STATE REGISTRAR James Thomas Smith
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES T. SMITH				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 2210 M	
4. SOCIAL SECURITY NUMBER 216-40-1318		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 9, 1943	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 74 E. North Avenue				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) soldier		16b. KIND OF BUSINESS/INDUSTRY army			
17. FATHER'S NAME (First, Middle, Last) George A. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irma Wellsworth Carey			
19a. INFORMANT'S NAME (Type/Print) Thelma E. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 E. North Avenue Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cemetery		DATE 10/12		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEPATIC FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC ACTIVE HEPATITIS (HEPATITIS C) DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 2 WEEKS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIO SCLEROTIC HEART DISEASE ACUTE RENAL FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10/10		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barry W. Carter, MD</i>		29c. LICENSE NUMBER D01040		29d. DATE SIGNED (Month, Day, Year) 10-07-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARRY W. CARTER, MD 18706 CHERWOOD RD, HAGERSTOWN MD, 21742							
31. DATE FILED (Month, Day, Year) OCT 11 1994		32. REGISTRAR'S SIGNATURE <i>James Thomas Smith</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret A. Smith				2. DATE OF DEATH MONTH DAY YEAR 10 2 94		3. TIME OF DEATH 12:35 A M	
4. SOCIAL SECURITY NUMBER 161-24-6458		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-18-1931	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH PA	
10a. STATE NJ				10b. COUNTY Cape May		10c. CITY, TOWN OR LOCATION Rio Grande	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 207 Vermont Avenue				10f. ZIP CODE 08242		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper		16b. KIND OF BUSINESS/INDUSTRY Motel			
17. FATHER'S NAME (First, Middle, Last) Bernard Toner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily ?			
19a. INFORMANT'S NAME (Type/Print) Christine M. Prasch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 Vineyard Road, Levittown, PA 19057-4206			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cape May Co. Crematory		DATE 10/4		20c. LOCATION — City or Town, State Lower Twp., NJ	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William S. Smith II</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anterior wall Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Colfer MD</i>				29c. LICENSE NUMBER OLME		29d. DATE SIGNED (Month, Day, Year) 10/2/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD J. COLFER MD 2013 TRAPPE CHURCH ROAD DARLINGTON, MD 21034							
31. DATE FILED (Month, Day, Year) OCT 04 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

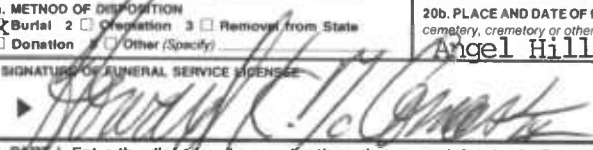


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30157

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH KYLE BRINKMAN SHEPPARD				2. DATE OF DEATH MONTH DAY YEAR Sept. 30, 1994		3. TIME OF DEATH 9:50 A M	
4. SOCIAL SECURITY NUMBER 216-05-3152		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 11, 1910	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2113 Trimble Road				10f. ZIP CODE 21040		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Line Worker		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) John Edward Brinkman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cameron Charshee			
19a. INFORMANT'S NAME (Type/Print) Patti A. Abbott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Janice Court, Joppa, Maryland 21085			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Angel Hill Cemetery 10-4-94		20c. LOCATION — City or Town, State Havre de Grace, Md.		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory failure DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): d. Restrictive lung disease, secondary kyphoscoliosis							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary tract infection							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D23446		29d. DATE SIGNED (Month, Day, Year) 9/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH.18 Rev 1/89



94 30159

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) WILLIE GLADYS SHIELDS				2. DATE OF DEATH MONTH 9 DAY 28 YEAR 94		3. TIME OF DEATH 0025 M	
4. SOCIAL SECURITY NUMBER 226-92-7719		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-13-1899	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE VIRGINIA		10b. COUNTY ACCOMACK	
10c. CITY, TOWN OR LOCATION JENKINS BRIDGE OAK HALL				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER	
10f. ZIP CODE 23416				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) HOUSEWIFE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) WILLIAM C. SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE MEARS			
19a. INFORMANT'S NAME (Type/Print) W. E. REDDEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) POCOMOKE CITY, MD 21851			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JOHN W. TAYLOR CEMETERY 9/30		20c. LOCATION — City or Town, State TEMPERANCEVILLE VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James H. Felt</i>				22. NAME AND ADDRESS OF FACILITY FOX FUNERAL HOME PO BOX 278, TEMPERANCEVILLE, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. HTN DUE TO (OR AS A CONSEQUENCE OF): d. CHF							
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. Renal failure - acute							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>London M. Miller MD</i>				29c. LICENSE NUMBER D43486		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3 Bi State Blvd, Delmar MD 21875							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE <i>John T. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30160

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ras Lee Smith				2. DATE OF DEATH MONTH DAY YEAR Sept. 28, 1994		3. TIME OF DEATH 10:58 a. m.	
4. SOCIAL SECURITY NUMBER 421-34-3833		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 7, 1920	
8. BIRTHPLACE (State or Foreign Country) Alabama				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Wheaton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 12519 Littleton Street	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Loan Executive		16b. KIND OF BUSINESS/INDUSTRY Farmers Home Admin.	
17. FATHER'S NAME (First, Middle, Last) Willie Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Foster			
19a. INFORMANT'S NAME (Type/Print) Daisy L. Smith (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12519 Littleton St., Wheaton, MD 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 10/1		20c. LOCATION — City or Town, State Bladensburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Browder</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Massive stroke</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>3 days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benjamin M.D.</i>				29c. LICENSE NUMBER DO 9834		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. N. ROSENBAUM 3720 HARRIS AVE KENSINGTON, MD 20751							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

Amended 10e,

9/26/94 MRT

Montgomery County 94 30161

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) HAROLD SAXON				2. DATE OF DEATH MONTH SEPTEMBER DAY 22 YEAR 1994				3. TIME OF DEATH 8:46 a.m. M	
4. SOCIAL SECURITY NUMBER 217-90-7529		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 34 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept 3, 1960		8. BIRTHPLACE (State or Foreign Country) Germany			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10225 Peanut Mill Drive				10f. ZIP CODE 20882		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Systems Analyst		16b. KIND OF BUSINESS/INDUSTRY Computer Management					
17. FATHER'S NAME (First, Middle, Last) Harry James Saxon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Goodwin					
19a. INFORMANT'S NAME (Type/Print) Karen K. Saxon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10225 Peanut Mill Dr., Gaithersburg, MD 20882					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 9-26-94		20c. LOCATION — City or Town, State Silver Spring, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louis J. Hunt</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD.					
22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Fulminant liver failure DUE TO (OR AS A CONSEQUENCE OF): Metastatic Cancer Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Renal failure, hypercalcemia								Approximate interval Between Onset and Death two weeks two weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure, hypercalcemia								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Cecil, MD</i>				29c. LICENSE NUMBER M0215		29d. DATE SIGNED (Month, Day, Year) 9/22/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J A CECIL, M.D. 600 N. Wolfe St, Baltimore, MD.									
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30162

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SAMUEL, SPERLING				2. DATE OF DEATH MONTH SEPT DAY 21 YEAR 1994		3. TIME OF DEATH 1:11 P	
4. SOCIAL SECURITY NUMBER 425-38-6040		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 29, 1916	
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6105 MONTROSE ROAD				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INFORMATION OFFICER		16b. KIND OF BUSINESS/INDUSTRY BUREAU OF RADIOLOGICAL HEALTH	
17. FATHER'S NAME (First, Middle, Last) JOSEPH SPERLING				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE BRANDE			
19a. INFORMANT'S NAME (Type/Print) JILL SPERLING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 371 CHECKER DRIVE - BUFFALO GROVE, IL 60089			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.) JUDEAN MEMORIAL GARDENS		20c. LOCATION — City or Town, State OLNEY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry M. Giese</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Coronary Artery Disease</i>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ischemic Cardiomyopathy</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. Davidson</i> Attending Physician		29c. LICENSE NUMBER D18084	
29d. DATE SIGNED (Month, Day, Year) 9/21/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2b) (Type, Print) D. D. FATE, JR., 6121 Montrose Rd, Rockville, MD 20852			
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #6, #7, #15 9/27/94 MRT Montgomery County 91 30 163
FOR
1 - STATE
REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) May C. Summers				2. DATE OF DEATH MONTH DAY YEAR September 19 1994				3. TIME OF DEATH 4:15 P M			
4. SOCIAL SECURITY NUMBER 579-30-4160		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 24 1926		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 17521 Old Baltimore Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Olney				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION Olney				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 17521 Old Baltimore Rd.				10f. ZIP CODE 20832		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13 or 5+) 1				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Technician			16b. KIND OF BUSINESS/INDUSTRY IBM				
17. FATHER'S NAME (First, Middle, Last) Arthur A. Weidner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Richardson							
19a. INFORMANT'S NAME (Type/Print) Arthur Weidner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17521 Old Baltimore Rd. Olney, Md. 20832							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Ft. Lincoln Cem. 9-22-94		DATE		20c. LOCATION — City or Town, State Brentwood Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul Brent Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi F.H. Inc. 11800 New Hampshire Ave. Silver Spring, Md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sudden Cardiac death</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CAO</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>immediate</i> <i>6 hr</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ventricular ectopy, 1st degree, 7HT sgs</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER 24571		29d. DATE SIGNED (Month, Day, Year) 9/21/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 45225 STODDY GROVE RD, Rockville MD											
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30164

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN SMITH				2. DATE OF DEATH MONTH DAY YEAR 09 25 94		3. TIME OF DEATH 11:55 PM	
4. SOCIAL SECURITY NUMBER 216-24-9875		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4 14 1911	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GALESVILLE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 947 W. BENNING ROAD			
10f. ZIP CODE 20765				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) WILLIAM DORSEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE DORSEY			
19a. INFORMANT'S NAME (Type/Print) FRANK SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 947 W. BENNING RD. GALESVILLE, MD. 20765			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EBENEZER CHURCH CEME. 9/29/94		20c. LOCATION — City or Town, State GALESVILLE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry S. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Myocardial Infarction Pneumonia							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Munda</i> Attending				29c. LICENSE NUMBER D 21776		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURYA P. MUNDRA, M.D./1600 CRAIN HIGHWAY, SW #106/GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) SEP 30 1994		32. REGISTRAR'S SIGNATURE <i>James A. Hurd</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

enrollment

94 30165

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harvey Eugene Stallings				2. DATE OF DEATH MONTH DAY YEAR Sept 27 1994		3. TIME OF DEATH 10:05P M	
4. SOCIAL SECURITY NUMBER 212-10-7801		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 12 1914	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Edgewater		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 36 South River Road				10f. ZIP CODE 21037		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY United States Naval Academy			
17. FATHER'S NAME (First, Middle, Last) Harry C. Stallings				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Cadle			
19a. INFORMANT'S NAME (Type/Print) Connie Spindle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Maple Road Riva, Maryland 21140			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Luther Palmer Cemetery 9/30/94		20c. LOCATION — City or Town, State Annapolis, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gaine L Phillips</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST e. <i>metastatic Prostate Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert M. Greenfield</i>		29c. LICENSE NUMBER D26373		29d. DATE SIGNED (Month, Day, Year) September 28, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Greenfield, M.D. 139 Old Solomons Island Rd. Annapolis, MD 21401 (410-224-2222)							
31. DATE FILED (Month, Day, Year) SEP 29 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30166

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NETTIE A. SCOTT				2. DATE OF DEATH MONTH SEPTEMBER DAY 21 YEAR 1994		3. TIME OF DEATH 6:03 A	
4. SOCIAL SECURITY NUMBER 216-36-6053		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 6 1939	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CHANTON	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE	
10c. CITY, TOWN OR LOCATION SUITLAND				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3527 TERRACE DRIVE APT. D	
10f. ZIP CODE 20746				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) NATHANIEL OFFER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA TASKER			
19a. INFORMANT'S NAME (Type/Print) REGINALD SCOTT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 TERRACE DR. APT. D SUITLAND, MD. 20746			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 9/24/94		20c. LOCATION — City or Town, State ANNAPOLIS, MD.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Larry M. Reese	
22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Am. neg. Reptic Phosces DUE TO (OR AS A CONSEQUENCE OF): Hypotensive DUE TO (OR AS A CONSEQUENCE OF): Pul. Edema DUE TO (OR AS A CONSEQUENCE OF): Pneumonia DIC Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John A. H. Attended				29c. LICENSE NUMBER D24-208		29d. DATE SIGNED (Month, Day, Year) 9-21-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABULHASSAN Ansari 8926 Woodlyard Road Chanton Maryland 20735							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30167

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT I. STANFIELD				2. DATE OF DEATH MONTH 9 DAY 23 YEAR 94		3. TIME OF DEATH 1:45 P M	
4. SOCIAL SECURITY NUMBER 084-03-2005		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1918	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) 2667 Carrollton Road		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2667 Carrollton Road	
10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Aviation Journalist		16b. KIND OF BUSINESS/INDUSTRY Journalism	
17. FATHER'S NAME (First, Middle, Last) Charles I. Stanfield				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne V. Sweeny			
19a. INFORMANT'S NAME (Type/Print) Lois C. Stanfield				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 10761 White Bear Lake, Minnesota 55110			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 9-25 Brentwood, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc., 147 Duke of Gloucester Street, Annapolis, Md. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Meter late carcinoma of lung. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Leukemia bone disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James Church, MD				29c. LICENSE NUMBER MD 1865		29d. DATE SIGNED (Month, Day, Year) 9/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GURMAN CHURCH 8 EVENING STAR RD SEVENTH PINE MD 21146							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30168

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BENJAMIN EGBERT SCHAFER				2. DATE OF DEATH MONTH DAY YEAR September 27, 1994		3. TIME OF DEATH 2:20P M	
4. SOCIAL SECURITY NUMBER 217-05-8926		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/25/1898	
9a. FACILITY NAME (If not institution, give street and number) Perry Point Veterans Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Perryville		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 139 Deaver Street				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War #1		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Railroad Industry			
17. FATHER'S NAME (First, Middle, Last) John Schaffer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice G. Lodore			
19a. INFORMANT'S NAME (Type/Print) Mrs. Hilda Gallagher				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Deaver Street, Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens		DATE 9/30		20c. LOCATION — City or Town, State Aberdeen, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Madelyn Mitchell Shank				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Probable New Cerebrovascular Accident</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Difused Vascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Glucose Intolerance</u>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Peripheral Vascular Disease</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER A.J. LUCCO M.D.		29c. LICENSE NUMBER D30951	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.J. LUCCO M.D., VA Medical Center, Perry Point, MD 21902				31. DATE FILED (Month, Day, Year) SEP 29 1994			
32. REGISTRAR'S SIGNATURE John A. Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30169

Emma Sarau

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMMA HELEN SARAU				2. DATE OF DEATH MONTH DAY YEAR Sept. 21 1994		3. TIME OF DEATH 7:20 P M	
4. SOCIAL SECURITY NUMBER 336-26-4231		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 22, 1906	
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & REHAB CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 29840 Deer Harbor Dr.	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Loan officer		16b. KIND OF BUSINESS/INDUSTRY credit	
17. FATHER'S NAME (First, Middle, Last) Adam (unk) Seidlitz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eugenia (unknown)			
19a. INFORMANT'S NAME (Type/Print) Barbara Sarau				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29840 Deer Harbor Dr., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac infarct</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Dementia</i> b. <i>Hypertension</i> c. <i>...</i> d. <i>...</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Robins, M.D.</i>				29c. LICENSE NUMBER 029349		29d. DATE SIGNED (Month, Day, Year) 9/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801							
31. DATE FILED (Month, Day, Year) SEP 23 1994				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1109

CLINTON FIELD

SEP 28 1994

R

SEP 28 1994

94-5702-001
B.K.S

94 30170

ITEMS: 23 PART I, 27, 28a, b, d, e, f PER MEO G-717 11/4/94 reb

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL ALLEN SHEETS				2. DATE OF DEATH MONTH DAY YEAR OCT. 1 94		3. TIME OF DEATH 7:52 P M				
4. SOCIAL SECURITY NUMBER 218-68-4988		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun 17, 1956		8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) MARKET & CUMBERLAND ST. WOODED AREA				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY			
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 16202 Wheeler Road				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Former Employee			16b. KIND OF BUSINESS/INDUSTRY Ballistics					
17. FATHER'S NAME (First, Middle, Last) Kenneth L. Sheets				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary J. (Sutton)						
19a. INFORMANT'S NAME (Type/Print) Sandra K. Sheets				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16202 Wheeler Road; Cumberland, MD 21502						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematorium 10/5		20c. LOCATION — City or Town, State Smithsburg, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE DRUG INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) WOODED AREA								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 10/1/94		28b. TIME OF INJURY found 6:27 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Maurice Beckwith				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 2, 1994		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD A. KOREN 111 Penn Street, Baltimore, Maryland 21201										
31. DATE FILED (Month, Day, Year) NOV - 4 1994				32. REGISTRAR'S SIGNATURE Julia D. Walker-Rodell						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30171

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN RIGGIN SMITH, SR.				2. DATE OF DEATH MONTH DAY YEAR Oct. 2, 1994		3. TIME OF DEATH 12:05 A.M.	
4. SOCIAL SECURITY NUMBER 214-28-3775		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24, 1930	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not Institution, give street and number) 221 South Blvd.		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
10a. STATE Maryland				10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 221 South Blvd.		10f. ZIP CODE 21801	
10g. CITIZEN OF WHAT COUNTRY? U.S.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA & VIETNAM	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Foreman				16b. KIND OF BUSINESS/INDUSTRY Construction		17. FATHER'S NAME (First, Middle, Last) John William Smith	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Pollitt				19a. INFORMANT'S NAME (Type/Print) Mrs. Gerlinde W. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 South Blvd., Salisbury, Md. 21801	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Manokin Presbyterian		20c. LOCATION — City or Town, State Pr. Anne, Md. 21853	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. H...</i> M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Acute Leukemia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Helen M. Boldado MD</i>				29c. LICENSE NUMBER D16840		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 547-F RIVERVIEW DRIVE Salisbury Md. 21801							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Alverta Smith</i>				2. DATE OF DEATH MONTH <i>9</i> - DAY <i>21</i> - YEAR <i>94</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>222-05-6501</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8-16-07</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Dorchester Gen. Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>		9c. COUNTY OF DEATH <i>Dorchester</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Cambridge</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>611 Earle Street</i>				10f. ZIP CODE <i>21613</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Grade 5</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>John Fletcher</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Henry</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Shirley Campbell</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2212 Shannon Dr. South San Francisco, Ca.</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Bethel Cemetery 10/1</i>		20c. LOCATION — City or Town, State <i>Cambridge, Md.</i>		22. NAME AND ADDRESS OF FACILITY <i>Henry Funeral Home 510 Washington St. Cambridge, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janette C. Henry</i>				22. NAME AND ADDRESS OF FACILITY <i>Henry Funeral Home 510 Washington St. Cambridge, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiopulmonary arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>lung CA. metastatic</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D42070</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/22/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>L. Kirwan 402 Byrn St Cambridge Md 21613</i>							
31. DATE FILED (Month, Day, Year) <i>SEP 30 1994</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30173

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Sangeorzan				2. DATE OF DEATH MONTH DAY YEAR September 28, 1994				3. TIME OF DEATH 1:23 AM	
4. SOCIAL SECURITY NUMBER 176-60-1766		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-28-1917		8. BIRTHPLACE (State or Foreign Country) Romania	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 101 Odend'hal Ave				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lawyer				16b. KIND OF BUSINESS/INDUSTRY Legal Profession	
17. FATHER'S NAME (First, Middle, Last) John Sangeorzan				18. MOTHER'S NAME (First, Middle, Maiden Surname) JoAnna Coritiu					
19a. INFORMANT'S NAME (Type/Print) Angela Sangeorzan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Odend'hal Ave. Apt 903 Gaithersburg, Md 20877					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 9-29 Smithsburg, Md.				20c. LOCATION — City or Town, State Smithsburg, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Box 86 Barnesville, Md. 20838					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE CARDIOMYOPATHY - CARDIOGENIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): b. ISCHEMIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. ATHEROSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 Weeks 14 Years									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISEASES								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE CERTIFIER 		29c. LICENSE NUMBER D 1614 J		29d. DATE SIGNED (Month, Day, Year) 9/28/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREBORIO KOH - SHADY GROVE RD 15205 - ROCKVILLE - MD.									
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

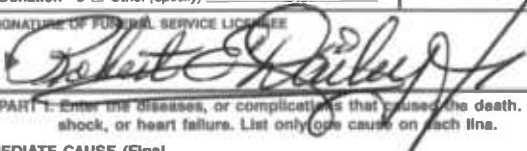

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30174

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARILYN MARIE STANN				2. DATE OF DEATH MONTH DAY YEAR Sept 28, 1994		3. TIME OF DEATH 3:00P	
4. SOCIAL SECURITY NUMBER 219-82-8659		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 21 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/20/1973	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Monrovia				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5001 Lee Hill Circle	
10f. ZIP CODE 21770				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years College (1-4 or 5+) Waitress				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Thomas H. Stann Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Rogner			
19a. INFORMANT'S NAME (Type/Print) Daniel Weddle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5001 Lee Hill Circle Monrovia, Maryland 21770			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 10/1		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Major Head and Chest Trauma DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Immed.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) Sept. 28, 1994		28b. TIME OF INJURY 3:00P	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED lost control vehicle head on collision			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Route #144 East of New Market, Md.				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01052		29d. DATE SIGNED (Month, Day, Year) Sept 29, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Dittolli MD 217 W. Washington St. Hagerstown, Md. 21740							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96

94 30175

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HASSON OSBERNT STEWART SR -				2. DATE OF DEATH MONTH 10 DAY 1 YEAR 94		3. TIME OF DEATH 12 05 A	
4. SOCIAL SECURITY NUMBER 214-10-5772		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-26-17	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 15 Peters Lane				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owned and Operated		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) John H. Stewart, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy TOPPER			
19a. INFORMANT'S NAME (Type/Print) Hasson Osbernt Stewart, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Cherokee Trail, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery, October 5, 1994		20c. LOCATION — City or Town, State Frederick, Maryland		20d. DATE October 5, 1994	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Hrap M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): HYPOKALEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 2 Hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPOTENSION							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER David M. Summers MD PHYSICIAN				29c. LICENSE NUMBER H39804		29d. DATE SIGNED (Month, Day, Year) 10-1-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. SUMMERS MD 915 TOLLHOUSE AVE., FREDERICK MD 21701							
31. DATE FILED (Month, Day, Year) OCT 03 1994				32. REGISTRAR'S SIGNATURE John Davelos-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,




TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30176

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH FLORENCE SHERRY				2. DATE OF DEATH MONTH DAY YEAR 10 5 94		3. TIME OF OATH 7:05 A M	
4. SOCIAL SECURITY NUMBER 218-50-4357		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 9, 1917	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF OATH FREDERICK		9c. COUNTY OF OATH FREDERICK	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION THURMONT		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7025 BLUE MOUNTAIN RD.				10f. ZIP CODE 21788		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) WILLIS RAY DEVILBISS				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA GRACE GEESEY			
19a. INFORMANT'S NAME (Type/Print) BETTY E. GRAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7025 BLUE MOUNTAIN RD., THURMONT, MD 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LEWISTOWN CEMETERY 10/7		20c. LOCATION — City or Town, State LEWISTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON, P.A. 615 E. MAIN ST., THURMONT, MD 21788			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ovarian cancer</u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> <u>Hypertension</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-CP191		29d. DATE SIGNED (Month, Day, Year) 10 5 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANNE G. MARSH, MD, 187 Thomas Johnson Dr. Frederick, MD 21702							
31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Ruth Amanda Tracey</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>3</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1240 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>189-07-1717</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>03/04/12</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Carroll County General Hospital</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i>		10. COUNTY OF DEATH <i>Carroll</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Hampstead</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4715 Maple Grove Road</i>				10f. ZIP CODE <i>21074</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i></i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>William A. Fishpaw</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bessie L. Crowther</i>			
19a. INFORMANT'S NAME (Type/Print) <i>David M. Tracey</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4715 Maple Grove Rd, Hampstead, MD 21074</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Trenton Cemetery</i>		DATE <i>10/6</i>		20c. LOCATION — City or Town, State <i>Upperco, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY <i>Eline Funeral Home 934 S Main St, Hampstead, MD 21074</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hemorrhagic shock</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Ruptured Abdominal Aortic aneurysm</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Steers MD</i>				29c. LICENSE NUMBER <i>D44614</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/3/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John A. Steers MD Carroll County Gen Hosp</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. Steers</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #17, #22

9/27/94

MRT

Montgomery

94 30178

County

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES STEPHAN TROGLIA				2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 25 1994		3. TIME OF DEATH 08:14 A M	
4. SOCIAL SECURITY NUMBER 217-76-1624		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 14, 1959	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 603 Twinbrook Parkway			
10f. ZIP CODE 20851				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Installer		16b. KIND OF BUSINESS/INDUSTRY Carpet Business			
17. FATHER'S NAME (First, Middle, Last) Paul Joe Troglia, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Roberly Ingersoll Weigle			
19a. INFORMANT'S NAME (Type/Print) Roberly W. Collins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Twinbrook Parkway, Rockville, MD 20851			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 9/26/94		20c. LOCATION — City or Town, State Alexandria, Virginia		20d. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST MULTIPLE SYSTEM FAILURE DRUG INGESTION PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28. DATE OF INJURY (Month, Day, Year)	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle				29c. LICENSE NUMBER 007099		29d. DATE SIGNED (Month, Day, Year) 9-25-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 27) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20812							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 196, 9/30/94, J.W. Montgomery Co.

94 30179

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mark Tucker				2. DATE OF DEATH MONTH DAY YEAR September 17/94		3. TIME OF DEATH M 1:30 P	
4. SOCIAL SECURITY NUMBER 104 60 4263		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/26/64	
8. BIRTHPLACE (State or Foreign Country) New York				9. COUNTY OF DEATH Prince Georges			
10. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Center				11. CITY, TOWN OR LOCATION OF DEATH Cheverly			
12. RESIDENCE OF DECEDENT				13. STATE Maryland		14. COUNTY Prince Georges	
15. STREET AND NUMBER 2102 Powder Horn Drive				16. ZIP CODE 20744		17. CITIZEN OF WHAT COUNTRY? USA	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: Caucasian	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		24. KIND OF BUSINESS/INDUSTRY Auto Sales	
25. FATHER'S NAME (First, Middle, Last) Thomas A. Tucker				26. MOTHER'S NAME (First, Middle, Maiden Surname) Helen M. Donahue			
27. INFORMANT'S NAME (Type/Print) Sharon Tucker				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Powder Horn Drive Fort Washington, MD 20744			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ivy Hill Cemetery 9/22 Alexandria, Virginia		31. DATE 9/22		32. LOCATION — City or Town, State Alexandria, Virginia	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE Diana L. Serro				34. NAME AND ADDRESS OF FACILITY Demaine Funeral Homes, Inc. Alexandria, Virginia 22314			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Shot wound to the head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							36. Approximate Interval Between Onset and Death
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							38. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
39. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
43. 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		44. 28a. DATE OF INJURY (Month, Day, Year) Sept 15-94		45. 28b. TIME OF INJURY 11:58 P		46. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
47. 28d. DESCRIBE HOW INJURY OCCURRED self inflicted		48. 29. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Residence bed room bathroom, 2102 Powder Horn Dr. Ft. Geo. Md					
49. 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. 29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez MD				51. 29c. LICENSE NUMBER A21230		52. 29d. DATE SIGNED (Month, Day, Year) September 18, 1994	
53. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Rayburn Ct, Cp. Spr. Md 20748							
54. 31. DATE FILED (Month, Day, Year) SEP 30 1994				55. 32. REGISTRAR'S SIGNATURE Jill Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30180

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hortense Alida TATRO				2. DATE OF DEATH MONTH DAY YEAR September 24 1994		3. TIME OF DEATH 12:30a.	
4. SOCIAL SECURITY NUMBER 578-48-8331		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 9, 1908	
9a. FACILITY NAME (If not institution, give street and number) Doctor's Community Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince George's	
10a. STATE MD.				10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION RIVERDALE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5906 48th AVE.			
10f. ZIP CODE 20737				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) CHARLES D. TRUDEL				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE MOISON			
19a. INFORMANT'S NAME (Type/Print) HORTENSE CORY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOT 25 SHILOH FARMS, LAUREL, DEL. 19956			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OUR LADY STAR OF THE SEA CHURCH CEM. SOLOMONS, MD.		20c. DATE 9/28		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.W. Chambers M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Hypertensive pulmonary phlebotic cardiorespiratory arrest					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez M.D.				29c. LICENSE NUMBER A71230		29d. DATE SIGNED (Month, Day, Year) September 25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AUGUSTO P. RODRIGUEZ M.D. 5009 RAYBURN CT., CAMP SPRINGS, MD.							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30181

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances F. <i>Truitt</i>				2. DATE OF DEATH MONTH DAY YEAR <i>September 19, 1994</i>		3. TIME OF DEATH M <i>2230</i>	
4. SOCIAL SECURITY NUMBER <i>220-09-1182</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 24, 1917</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9. FACILITY NAME (If not institution, give street and number) <i>PENINSULA REGIONAL MEDICAL CENTER</i>			
10. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>				11. COUNTY OF DEATH <i>WICOMICO</i>			
12a. STATE <i>MD</i>		12b. COUNTY <i>Wicomico</i>		12c. CITY, TOWN OR LOCATION <i>Pittsville</i>		12d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. STREET AND NUMBER <i>34534 Railroad Avenue</i>				14. ZIP CODE <i>21850</i>		15. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
16. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>College</i>		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		22. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
23. FATHER'S NAME (First, Middle, Last) <i>Lemuel P. Brown</i>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Goldie A. Walker</i>			
25. INFORMANT'S NAME (Type/Print) <i>Edward R. Truitt</i>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>34534 Railroad Ave., Pittsville, MD 21850</i>			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Pittsville Cemetery 9/23/94</i>		29. LOCATION — City or Town, State <i>Pittsville, MD</i>			
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. [Signature]</i>				31. NAME AND ADDRESS OF FACILITY <i>Hastings Funeral Home, Selbyville, DE 19975</i>			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrest</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>Stroke</i>							
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<i>atrial fibrillation</i> <i>chronic lymphocytic leukemia</i> <i>emphysema</i>							
33. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
35. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		36. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		38. DATE OF INJURY (Month, Day, Year)		39. TIME OF INJURY M		40. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				42. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
43. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
44. SIGNATURE AND TITLE OF CERTIFIER <i>Anny D. Walsh, MD</i>				45. LICENSE NUMBER <i>D46137</i>		46. DATE SIGNED (Month, Day, Year) <i>9/20/94</i>	
47. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Anny D. Walsh, MD, 100 East Canon St. Salisbury MD 21801</i>							
48. DATE FILED (Month, Day, Year) <i>SEP 22 1994</i>		49. REGISTRAR'S SIGNATURE <i>Johi Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


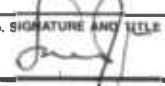
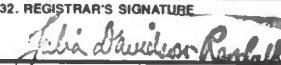
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30182

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERBERT DANIEL THOMPSON				2. DATE OF DEATH MONTH DAY YEAR Oct. 4, 1994		3. TIME OF DEATH 8:30 P. M.	
4. SOCIAL SECURITY NUMBER 217-28-5096		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 22, 1933	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 32 Sagner Court				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) City Employee		15b. KIND OF BUSINESS/INDUSTRY Light Department			
17. FATHER'S NAME (First, Middle, Last) Leroy Thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Posey			
19a. INFORMANT'S NAME (Type/Print) Theodosia E. Thompson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Sagner Court Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery		DATE 10/8/94		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RENAL FAILURE. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ASPIRATION PNEUMONIA b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① DEMENTIA ② HYPERTENSION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-4-94		28b. TIME OF INJURY 2035 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D43091		29d. DATE SIGNED (Month, Day, Year) 10-5-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAREN ZAIDI 801 TOLL HOUSE AVE, FREDERICK, MD							
31. DATE FILED (Month, Day, Year) OCT 07 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEREY NMN UBER				2. DATE OF DEATH MONTH 10 DAY 06 YEAR 94				3. TIME OF DEATH 1740 M			
4. SOCIAL SECURITY NUMBER 220-03-0118		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 28, 1916	8. BIRTHPLACE (State or Foreign Country) Maryland						
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH WASHINGTON CO.			
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 13217 Glendale Drive				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic Supervisor		16b. KIND OF BUSINESS/INDUSTRY Federal Government					
17. FATHER'S NAME (First, Middle, Last) Jacob O. Uber				18. MOTHER'S NAME (First, Middle, Maiden Surname) Isebell Hignutt							
19a. INFORMANT'S NAME (Type/Print) Edith S. Uber		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13217 Glendale Drive, Hagerstown, Maryland 21742									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls Cemetery Oct. 10, 1994		20c. LOCATION — City or Town, State Clear Spring, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Fiery				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 21742 1331 Eastern Blvd. North Hagerstown, Maryland							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NON OAT CELL CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE d. ABDOMINAL AORTIC ANEURYSM								Approximate Interval Between Onset and Death 2 MOS.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TRANSIENT ISCHEMIC ATTACK								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Mark Jameson MD						29c. LICENSE NUMBER 031537		29d. DATE SIGNED (Month, Day, Year) 10/6/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Jameson, Washington County Hospital											
31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE John B. Newkirk									

94 30184

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Kathleen J. Vaughn</i>				2. DATE OF DEATH MONTH <i>09</i> DAY <i>23</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>0330</i> M	
4. SOCIAL SECURITY NUMBER <i>577-04-2254</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>30</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 8, 1963</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Takoma Park</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Takoma Park</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8507 Garland Ave.</i>				10f. ZIP CODE <i>20912</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>clerk</i>		16b. KIND OF BUSINESS/INDUSTRY <i>sightseeing company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Kenneth J. Vaughn, Jr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Dorothy E. Eichner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Dorothy E. Vaughn</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8507 Garland Ave. Takoma Park, MD 20912</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Tracy Grove Cemetery 9/29/94</i>		20c. LOCATION — City or Town, State <i>Hendersonville, NC</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dorothy E. Vaughn</i>				22. NAME AND ADDRESS OF FACILITY <i>Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac heart attack</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Juvenile DM with end stage renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <i>Smith S. Ho M.D.</i>
29c. LICENSE NUMBER <i>D21900</i>							29d. DATE SIGNED (Month, Day, Year) <i>9/23/94</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SMITH S. HO 7610 Carroll Ave #280 Takoma Park md. 20912</i>							
31. DATE FILED (Month, Day, Year) <i>SEP 27 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00100

EWLECC POCMD

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EWLECC POCMD

94 30185

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wolfe S. van Eyken				2. DATE OF DEATH MONTH DAY YEAR Sept. 25, 1994		3. TIME OF DEATH 3:26A M	
4. SOCIAL SECURITY NUMBER 501-32-8608		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 22, 1923	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 703 Wilson Avenue				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) — College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chemist		16b. KIND OF BUSINESS/INDUSTRY GSA			
17. FATHER'S NAME (First, Middle, Last) Wolfgang van Eyken				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hertha Von Holzapfel			
19a. INFORMANT'S NAME (Type/Print) Maria E. van Eyken				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Wilson Avenue, Rockville, Maryland 20850			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery 9/28/94		20c. LOCATION — City or Town, State Rockville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myeloid Metaplasia with Anemia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF, Aortic Stenosis, SPO, Chronic Renal Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. Macon M.D.</i>				29c. LICENSE NUMBER D06945		29d. DATE SIGNED (Month, Day, Year) September 26, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. Macon, M.D., 809 Viers Mill Road, Rockville, Maryland 20851							
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30186

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL CURTIS VINCENT				2. DATE OF DEATH MONTH DAY YEAR September 19, 1994		3. TIME OF DEATH 1:02 a m	
4. SOCIAL SECURITY NUMBER 220-66-3340		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 12, 1955	
9a. FACILITY NAME (If not institution, give street and number) 7960 Hurley Neck Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Mardela Springs		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Mardela Springs		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER #7960 Hurley Neck Rd.				10f. ZIP CODE 21837		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Type setter		16b. KIND OF BUSINESS/INDUSTRY Publication Co.			
17. FATHER'S NAME (First, Middle, Last) Joseph William Vincent				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Ann Feick			
19a. INFORMANT'S NAME (Type/Print) Ruth Vincent				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #7960 Hurley Neck Rd., Mardela Springs, MD 21837			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		DATE 9/20		20c. LOCATION — City or Town, State Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired immune deficiency							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DR674		29d. DATE SIGNED (Month, Day, Year) 9/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.A. Cockey, M.D. Wicomico County Health Dept. Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) SEP 22 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30187

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARREN, George GEORGE WOODROW WARREN				2. DATE OF DEATH MONTH 23 DAY 94 YEAR 6:10 PM		3. TIME OF DEATH 6:10 PM	
4. SOCIAL SECURITY NUMBER 222-10-2605		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-29-12	
9a. FACILITY NAME (If not institution, give street and number) HARRISON HOUSE, SNOW HILL				9b. CITY, TOWN OR LOCATION OF DEATH SNOW HILL		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION 10718 Cathell Road, Berlin, Maryland		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10718 Cathell Road				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES XX		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Motor Company	
17. FATHER'S NAME (First, Middle, Last) Peter Warren				18. MOTHER'S NAME (First, Middle, Maiden Surname) Arkansas Martha Ann Jarman			
19a. INFORMANT'S NAME (Type/Print) Connie Beacht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10027 Keyser Pt. Rd. Ocean City, MD 21842			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		20c. LOCATION — City or Town, State 9/26/94 Berlin, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY 108 Williams St. Burbage Funeral Home Berlin, MD 21811			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of the Prostate, end stage							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Diabetes Coronary Artery Disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Belluso, M.D.				29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 9-23-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, MD 4421 BEECHWOOD PL., CRISFIELD, MD 21817							
31. DATE FILED (Month, Day, Year) SEP 26 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

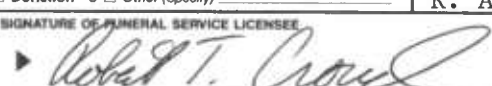

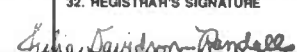
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) MYRON WRIGHT				2. DATE OF DEATH MONTH October DAY 3 YEAR 1994		3. TIME OF DEATH 4:00 A M	
4. SOCIAL SECURITY NUMBER 216-12-7114		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 27, 1921	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Perry Point VA Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1997 Turkey Point Road	
10f. ZIP CODE 21901				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pharmacist		15b. KIND OF BUSINESS/INDUSTRY Retail Pharmacy			
16. DECEASED'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)				17. FATHER'S NAME (First, Middle, Last) Joseph Wright			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown ALLICE WRIGHT				19a. INFORMANT'S NAME (Type/Print) Richard C. Wright			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1977 Turkey Point Road, North East, MD 21901				20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris Crematory 10/3/94 West Chester, Penna.				20c. LOCATION — City or Town, State Crouch Funeral Home 127 South Main Street, North East MD 21901			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis a. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D32395		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS FINUCAN, M.D., VAMC Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) OCT 04 '94				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

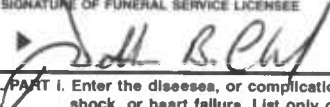

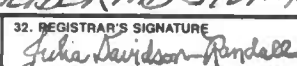
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30189

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY C. T. WAGNER				2. DATE OF DEATH MONTH DAY YEAR SEPT. 22, 1994		3. TIME OF DEATH 10:15 P M	
4. SOCIAL SECURITY NUMBER 577-40-7490		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 8, 1907	
8. BIRTHPLACE (State or Foreign Country) Nebraska				9. COUNTY OF DEATH Prince George's			
9a. FACILITY NAME (If not institution, give street and number) Carroll Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington, D.C.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 200 Rhode Island Ave, N.W.				10f. ZIP CODE 20002		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Dept. of Defense			
17. FATHER'S NAME (First, Middle, Last) Carl Wagner, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Bauer			
19a. INFORMANT'S NAME (Type/Print) Fr. Regis Jordan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2131 Lincoln Rd, NE Washington, DC 20002			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		DATE 9-26		20c. LOCATION — City or Town, State Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MARTHA ANNE SCHNEIDER MD				29c. LICENSE NUMBER D26331		29d. DATE SIGNED (Month, Day, Year) Sept. 23, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTHA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20006							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE  Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30190

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Esther Louise Warsaw</i>				2. DATE OF DEATH MONTH DAY YEAR <i>September 23 1994</i>		3. TIME OF DEATH <i>7:15 P M</i>	
4. SOCIAL SECURITY NUMBER <i>577-52-0067</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8/15/07</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Healthcare Center eAspenwood</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>15210 Elridge Way Apt. 1 C</i>			
10f. ZIP CODE <i>20906</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary 12 (0-12)</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>ABE COHEN</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>CARRYE MOSER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JOSEPH M. WARSAW</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20000 BELLE CHASE DR. GAITHERSBURG, MD. 20882</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ADAS ISAREL HEBREW CONG. 9/26</i>		20c. LOCATION — City or Town, State <i>WASHINGTON D.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph M. Peters</i>				22. NAME AND ADDRESS OF FACILITY <i>JOSEPH GAWLER'S SONS 5130 WISCONSIN AVE. N.W. WASHINGTON D.C.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Dehydration + malnutrition</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Profound Dementia.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Lung Disease</i> <i>Anemia</i> <i>Probable old stroke.</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart Turkewitz M.D.</i>				29c. LICENSE NUMBER <i>D31001</i>		29d. DATE SIGNED (Month, Day, Year) <i>9/23/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stuart Turkewitz, M.D. 2500 Greenway Cntr. Dr. #430 Greenbelt, Md. 20770</i>							
31. DATE FILED (Month, Day, Year) <i>SEP 27 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julian...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6:00



Amended #2, #4, 9/27/94 MRT Montgomery County 94 30191
 FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marvel Amelia Werner				2. DATE OF DEATH Sept 23, 1994		3. TIME OF DEATH 12:38 A M	
4. SOCIAL SECURITY NUMBER 578-18-1383		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 19, 1912	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Foundation (Ashley Glen)		9b. CITY, TOWN OR LOCATION OF DEATH Olney	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Takoma Park				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 17 Darwin Avenue	
10f. ZIP CODE 20912				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner		16b. KIND OF BUSINESS/INDUSTRY Bakery	
17. FATHER'S NAME (First, Middle, Last) Timothy Murray				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Elizabeth Sweeney			
19a. INFORMANT'S NAME (Type/Print) Barbara A. Bailer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Gadsden Avenue Silver Spring, Maryland 20905			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 9/26/94		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy D. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → colon cancer Approximate interval between Onset and Death 3 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g.			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bruce A. Silver, MD				29c. LICENSE NUMBER D21463		29d. DATE SIGNED (Month, Day, Year) 9/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE A. SILVER, M.D. 2101 MEDICAL PARK DRIVE SILVER SPRING, MARYLAND 20902							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30192

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Glenn Edward Wood				2. DATE OF DEATH MONTH DAY YEAR September 25, 1994		3. TIME OF DEATH 10:15 P M	
4. SOCIAL SECURITY NUMBER 220-34-3412		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1911	
8. BIRTHPLACE (State or Foreign Country) Oklahoma				9a. FACILITY NAME (If not institution, give street and number) 968 Riversedge Circle		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 968 Riversedge Circle	
10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed		16b. KIND OF BUSINESS/INDUSTRY Wood's Farm Market	
17. FATHER'S NAME (First, Middle, Last) Andrew Wood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Schooley			
19a. INFORMANT'S NAME (Type/Print) Vergie Mae Wood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 968 Riversedge Circle Annapolis, Maryland 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery 9/28/94		20c. LOCATION — City or Town, State Gaithersburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GASTRIC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Stroke, Ulcer							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel Rosenblum MD				29c. LICENSE NUMBER D04766		29d. DATE SIGNED (Month, Day, Year) 9-26-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL ROSENBLUM 10400 CORNWAT AV 606 KENSINGTON, MD 20945							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30193

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth LANDES Woodward				2. DATE OF DEATH MONTH DAY YEAR Sept 21 94		3. TIME OF DEATH 6 05 PM	
4. SOCIAL SECURITY NUMBER 216-48-0281		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24, 1907	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STREET AND NUMBER 2 Keystone Court				10f. ZIP CODE 20878		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) John Irvin Landes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Allebach Markley			
19a. INFORMANT'S NAME (Type/Print) Ruth Ann Bond				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Keystone Court, Gaithersburg, Maryland 20878			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park		DATE 9/24		20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Culbert</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerotic Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death Hours Hours Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left upper extremity paralysis due to cervical cord compression.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Byrl D. Johnson M.D.</i>				29c. LICENSE NUMBER 0-19042		29d. DATE SIGNED (Month, Day, Year) 9/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BYRL D. JOHNSON 911 RUSSELL AVENUE GAITHERSBURG, MD. 20879							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30194

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK WOLIN				2. DATE OF DEATH MONTH 09 DAY 28 YEAR 94		3. TIME OF DEATH 1:00 PM	
4. SOCIAL SECURITY NUMBER 577-05-3151		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-22-10	
8. BIRTHPLACE (State or Foreign Country) RUSSIA				9a. FACILITY NAME (If not institution, give street and number) COLLINGSWOOD NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION BETHESDA				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7420 WESTLAKE TERRACE #708	
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL	
17. FATHER'S NAME (First, Middle, Last) CHARLES WOLIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BAYLA SCHLONSKY			
19a. INFORMANT'S NAME (Type/Print) LINDA GLAUBACH WOLIN (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7420 WESTLAKE TERRACE #708, BETHESDA, MD 20817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDEN 9/30 FALLS CHURCH, VA		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joyce E. Torchinsky</i> JOYCE E. TORCHINSKY				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → dementia Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): atherosclerosis c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 035703		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Vaccarezza 6240 Montrose Rd Rockville MD 20852							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30195

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY MAE WALDMANN				2. DATE OF DEATH MONTH DAY YEAR Sept. 27, 1994		3. TIME OF DEATH 1:15A M	
4. SOCIAL SECURITY NUMBER 219-20-4758		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 18, 1903	
9a. FACILITY NAME (If not institution, give street and number) 205 St. Mark Way Apt. 115				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 205 St. Mark Way Apt. 115			
10f. ZIP CODE 21158				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Aide		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) Harry John Pankhurst				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet Lillian Fletcher			
19a. INFORMANT'S NAME (Type/Print) Ludwig Waldmann				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 St. Mark Way Apt 115, Westminster, MD 21158			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Ridge Memorial Park 10/1		20c. LOCATION — City or Town, State Elkridge, Maryland		20d. DATE 10/1	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Guerra-Lakerty/Hyles</i>				22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis Street, Westminster, MD 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Syr.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension - Congestive Heart Failure							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wilbur H. Foard MD</i>				29c. LICENSE NUMBER 002386		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wilbur H. Foard 3223 Main Street, Manchester, MD 21102							
31. DATE FILED (Month, Day, Year) SEP 29 1994				32. REGISTRAR'S SIGNATURE <i>James Davidson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

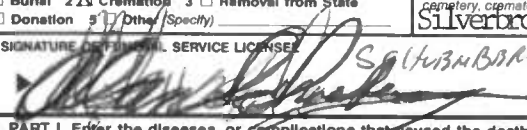
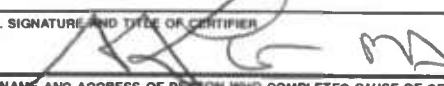

Amended Items 6, 7 & 18 9/28/94 Lm. Cecil Co.
Amended Item 9c. 9/23/94 RV Cecil Co.

94 30196

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DUANE WAYMAN				2. DATE OF DEATH MONTH DAY YEAR September 20, 1994		3. TIME OF DEATH 8 P M					
4. SOCIAL SECURITY NUMBER 375-40-0240		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 13, 1921		8. BIRTHPLACE (State or Foreign Country) Wellington, CO			
9a. FACILITY NAME (If not institution, give street and number) Veterans Affairs Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point				9c. COUNTY OF DEATH Harford Cecil			
RESIDENCE OF DECEDENT											
10a. STATE Delaware		10b. COUNTY New Castle		10c. CITY, TOWN OR LOCATION Wilmington				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER P.O. Box 4533				10f. ZIP CODE 19807		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military Officer		16b. KIND OF BUSINESS/INDUSTRY U.S. Army					
17. FATHER'S NAME (First, Middle, Last) Cleophus Wayman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Freeman Whitright							
19a. INFORMANT'S NAME (Type/Print) Duane L. Wayman II				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 4533, Wilmington, DE 19807							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Silverbrook Crematory		DATE Sep. 23, 1994		20c. LOCATION — City or Town, State Wilmington, DE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SCITUATONC MBMUAL CHAPRI 519 PHILA PIKE W.L.M. DB. 15809							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Possible Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Possible Bowel Obstruction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Dementia End Stage Parkinsons Disease						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30951		29d. DATE SIGNED (Month, Day, Year) 8-20-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.J. LUCCO, M.D., VA Medical Center, Perry Point, MD 21902											
31. DATE FILED (Month, Day, Year) SEP 23 94				32. REGISTRAR'S SIGNATURE 							

94 30197

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Letitia M. WorriLOW				2. DATE OF DEATH MONTH DAY YEAR September 18, 1994		3. TIME OF DEATH 1945 M	
4. SOCIAL SECURITY NUMBER 212-38-4466		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 3, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1811 Telegraph Road				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Schoolteacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Edward Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma L. Scarborough			
19a. INFORMANT'S NAME (Type/Print) Albert V. Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Fair Hill Drive - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sharps Cemetery 9/22/94		20c. LOCATION — City or Town, State Fair Hill, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Progressive</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Organic brain syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ASVD</i> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Johnnie Lee M.D.</i>				29c. LICENSE NUMBER D04023		29d. DATE SIGNED (Month, Day, Year) 9/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui Chih Hsu, MD 223 West Main St. Elkton Md 21921							
31. DATE FILED (Month, Day, Year) SEP 23 '94				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-716 10/7/94 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) KENNETH GERALD WRIGHT			2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24, 1994		3. TIME OF DEATH 11:42A M	
4. SOCIAL SECURITY NUMBER 219-52-0279		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 27, 1949
8. BIRTHPLACE (State or Foreign Country) MD			9a. FACILITY NAME (If not institution, give street and number) CUMBERLAND MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND
9c. COUNTY OF DEATH ALLEGANY			10a. STATE WV			10b. COUNTY Mineral
10c. CITY, TOWN OR LOCATION Ridgeley			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 1 Box 105 J			10f. ZIP CODE 26753			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-employed		16b. KIND OF BUSINESS/INDUSTRY Carpenter	
17. FATHER'S NAME (First, Middle, Last) Lawrence Wright			18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah (McAteer)			
19a. INFORMANT'S NAME (Type/Print) Jane Wright			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 105 J; Ridgeley, WV 26753			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Facility, City, State, Zip Code) Smithsburg Crematorium 9/28		20c. LOCATION — City or Town, State Smithsburg, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Scarpelli</i>			22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE DRUG INTOXICATION (HYDROCODONE, OXYCODONE) DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 9/24/94		28b. TIME OF INJURY 10:30A M		
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED UNKNOWN				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) RT. 1, RIDGELY RD. MINERAL, W. VA				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R Fowler</i>			29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) SEPTEMBER 24, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201						
31. DATE FILED (Month, Day, Year) OCT 07 1994		32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>				

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



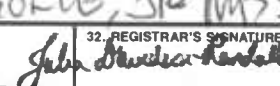
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDNA M. WHITE				2. DATE OF DEATH MONTH DAY YEAR OCT 02 94		3. TIME OF DEATH 3:02 A.M.	
4. SOCIAL SECURITY NUMBER 217-44-1808		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 7, 1946	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH WICOMICO COUNTY			
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO COUNTY	
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Princess Anne		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 30269 Mt. Vernon Road				10f. ZIP CODE 21853		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Alfred S. May				18. MOTHER'S NAME (First, Middle, Maiden Surname) Monie Pusey			
19a. INFORMANT'S NAME (Type/Print) Mr. Frederick L. White				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30269 Mt. Vernon Rd., Pr. Anne, Md. 21853			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory 10/3 Salisbury, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY THROMBOEMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 02, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARKIO F. GOLUB, JR. MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 04 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


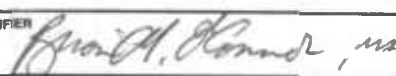

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2007-08-01 10:00

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES S. WISNER, Jr.				2. DATE OF DEATH MONTH DAY YEAR Oct. 1, 1994		3. TIME OF DEATH 1:30 P M	
4. SOCIAL SECURITY NUMBER 215-14-1567		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 6, 1918	
9a. FACILITY NAME (If not institution, give street and number) 5741 Shookstown Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5741 Shookstown Rd.				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Trucking Company	
17. FATHER'S NAME (First, Middle, Last) Charles S. Wisner, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Goldie Mae			
19a. INFORMANT'S NAME (Type/Print) Joan K. Wisner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5741 Shookstown Rd./ Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery		DATE 10-4		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, Md. 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCINOMA OF THE RECTUM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 2 YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28h. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 31761		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST. FREDERICK, MD 21701							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30201

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) William Leatherman Waters				2. DATE OF DEATH MONTH DAY YEAR Sept 27 1994		3. TIME OF DEATH 0034 M	
4. SOCIAL SECURITY NUMBER 220-34-2407		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 103 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1890	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEASED							
10a. STATE Md.		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Myersville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9369 Myersville Rd.				10f. ZIP CODE 21773		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer		15b. KIND OF BUSINESS/INDUSTRY farm owner			
17. FATHER'S NAME (First, Middle, Last) James Kinna Waters				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Leatherman			
19a. INFORMANT'S NAME (Type/Print) Miriam W. Kopp				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8909 Gloria Ave., Myersville, Md. 21773			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lutheran Cemetery		20c. LOCATION — City or Town, State 9/29 Middletown, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald B. Thompson</i>				22. NAME AND ADDRESS OF FACILITY Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 weeks year							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald B. Thompson</i>				29c. LICENSE NUMBER 02457		29d. DATE SIGNED (Month, Day, Year) 9/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABOUL WAKEED, MD - 12821-OAK HILL AVE HAGERSTOWN MD							
31. DATE FILED (Month, Day, Year) SEP 30 1994				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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94 30202

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leslie Eugene WILES				2. DATE OF DEATH MONTH September DAY 29, YEAR 1994				3. TIME OF DEATH 4:45 PM		
4. SOCIAL SECURITY NUMBER 214-10-4833		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH MONTH February DAY 29, YEAR 1904		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 6418 Jefferson Pike				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 6418 Jefferson Pike				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic			16b. KIND OF BUSINESS/INDUSTRY Automobiles			
17. FATHER'S NAME (First, Middle, Last) Charles Eugene WILES				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertie FULMER						
19a. INFORMANT'S NAME (Type/Print) Mrs. Loretta Jean Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Lakin Avenue, Boonsboro, Maryland 21713						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory September 30, 1994			20c. LOCATION — City or Town, State Smithsburg, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. May MOO255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF THE LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 3 mos		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D-31912		29d. DATE SIGNED (Month, Day, Year) 9/30/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Julio Menocal MD 516 Trail Avenue, Frederick, Maryland 21701										
31. DATE FILED (Month, Day, Year) OCT 03 1994		32. REGISTRAR'S SIGNATURE Julio Menocal								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30203

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Isabel Chase Yerger				2. DATE OF DEATH MONTH OCT DAY 2 YEAR 1994		3. TIME OF DEATH 0440 M	
4. SOCIAL SECURITY NUMBER 208-40-2787		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 10, 1906	
8. BIRTHPLACE (State or Foreign Country) Penna.				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 800 Motter Avenue	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker				16b. KIND OF BUSINESS/INDUSTRY home			
17. FATHER'S NAME (First, Middle, Last) Edwin Theodore Chase III				18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabel Crow			
19a. INFORMANT'S NAME (Type/Print) Sandra Wayne Anderer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 Woodlyn Road Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 10/6		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF) Pneumonia b. DUE TO (OR AS A CONSEQUENCE OF) Centriobasilar Arteriosclerosis c. DUE TO (OR AS A CONSEQUENCE OF) Accident d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration Arteriosclerosis Cardiovascular Disease Cerebral Heart Failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. J. M. M. M.</i>			
29c. LICENSE NUMBER D18019				29d. DATE SIGNED (Month, Day, Year) 10-6-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA MD 334 MILL ST HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) OCT 05 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

12

94 30204

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth C. Ziese				2. DATE OF DEATH MONTH DAY YEAR September 26, 1994		3. TIME OF DEATH 5:40 A M	
4. SOCIAL SECURITY NUMBER 212-54-1266		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1947	
9a. FACILITY NAME (If not institution, give street and number) 4820 Creek Shore Drive				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4820 Creek Shore Drive				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Carter Leach				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Mae MacMillian			
19a. INFORMANT'S NAME (Type/Print) William C. Ziese				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore-Washington Crem 9-26		20c. LOCATION — City or Town, State Laurel, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen W. Rupp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Acquired Immune Deficiency Syndrome Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 4 yr.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. J. Mayo, MD				29c. LICENSE NUMBER D23630		29d. DATE SIGNED (Month, Day, Year) 9-26-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK J. MAYO, MD 16220 Frederick RD #213, G. Falls, MD 20833							
31. DATE FILED (Month, Day, Year) SEP 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30205

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN K. ALT				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 1:45 P. M.	
4. SOCIAL SECURITY NUMBER 212-01-1490		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-24-07	
9a. FACILITY NAME (If not institution, give street and number) AUGSBURG LUTHERAN HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH MARYLAND	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION 21207		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6825 CAMPFIELD ROAD				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY ELEMENTARY SCHOOL			
17. FATHER'S NAME (First, Middle, Last) JACOB BRUNING KNIPP				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE WARING			
19a. INFORMANT'S NAME (Type/Print) CAROL WATSON (NIECE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 SHORE DRIVE JOPPA, MARYLAND 21085			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LAKEVIEW CEMETERY 10-14-94		20c. LOCATION — City or Town, State SYKESVILLE MARYLAND		20d. DATE 10-14-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MITRAL VALVE INSUFFICIENCY CONGESTIVE HEART FAILURE							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> 8		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tasneem Akram MD</i>					
29c. LICENSE NUMBER D28595		29d. DATE SIGNED (Month, Day, Year) 10/12/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TASNEEM AKRAM, 7220 PARK HEIGHTS AVE BALTO, MD 21208							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30206

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Adams				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 94		3. TIME OF DEATH 4:40 a m	
4. SOCIAL SECURITY NUMBER 220-44-1445		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 28, 1897	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Fairhaven		9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll County	
10c. CITY, TOWN OR LOCATION Sykesville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7200 Third Avenue	
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Domestic	
17. FATHER'S NAME (First, Middle, Last) Hermon Block				16. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Perine			
19a. INFORMANT'S NAME (Type/Print) Mrs. Hazel Myers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6304 Freedom Avenue Sykesville, MD 21784			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Serv. 10/14/94 Hampstead, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian A. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COLON CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ellis Mez MD				29c. LICENSE NUMBER D22220		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ellis Mez MD 1645 Liberty Road Eldersburg, MD, 21784							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE Richard Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30207

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMERSON NMN BELL				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 8, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 222-07-8507		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 26, 1908	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 8221 Appalachian Drive		9b. CITY, TOWN OR LOCATION OF DEATH Pasadena	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8221 Appalachian Drive	
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Peacetime				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ———				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer		16b. KIND OF BUSINESS/INDUSTRY Baking Company	
17. FATHER'S NAME (First, Middle, Last) Thomas Bell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Essey Bell			
19a. INFORMANT'S NAME (Type/Print) Mrs. Joan Mioduszewski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Maple Avenue Glen Burnie, Maryland 21061			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 10/11/94		20c. LOCATION — City or Town, State Baltimore, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Death Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. AS Atherosclerotic Cardiovascular Disease 5 years b. Pankreatic Disease 5 years c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER P20094		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7845 Oakwood Rd Glen Burnie, MD 21061							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30208

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATIE H BRUNGARD				2. DATE OF DEATH MONTH 10 DAY 09 YEAR 1994		3. TIME OF DEATH 01:00 M	
4. SOCIAL SECURITY NUMBER 245-36-8906		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-19-1930	
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore (Brooklyn Park)		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 500 Cresswell Road,				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Housewife			
17. FATHER'S NAME (First, Middle, Last) William Edgar Barnes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruda Blake			
19a. INFORMANT'S NAME (Type/Print) Mrs. Yvonne M. Brungard-Jung				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Woodlawn Avenue, Falls Church, Va. 22042			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veteran Cemetery 10/12		20c. LOCATION — City or Town, State Crownsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD PGY3 RESIDENT				29c. LICENSE NUMBER AS2441614-19		29d. DATE SIGNED (Month, Day, Year) 10/09/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABDUL K. GARNBA, HARBOR HOSPITAL CIR., 3001 S. HANOVER ST., BALTIMORE, MD 21225							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>Julius [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30209

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH J BANISTER				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 06:17 AM M	
4. SOCIAL SECURITY NUMBER 216-30-8854		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-7-34	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital Association				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7992 Solley Road				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (13-16) ---		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Lady		16b. KIND OF BUSINESS/INDUSTRY Market			
17. FATHER'S NAME (First, Middle, Last) William Leroy Wroten				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Fogler			
19a. INFORMANT'S NAME (Type/Print) Mr. Elmer J. Banister, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7992 Solley Road Glen Burnie, MD. 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 10/15/94		20c. LOCATION — City or Town, State Elkridge, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Elmer J. Banister, Sr.</i>				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Vertebral artery aneurysm</i>					Approximate Interval Between Onset and Death <i>1 Year</i>
		b. <i>Consequent heart failure</i>					<i>3 years</i>
		c. <i>Ischemic heart disease</i>					<i>3 years</i>
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin J. Doyle</i>				29c. LICENSE NUMBER D31122		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. DOYLE, M.D./203 HOSPITAL DRIVE, #206/GLEN BURNIE, MARYLAND							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John Benison-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


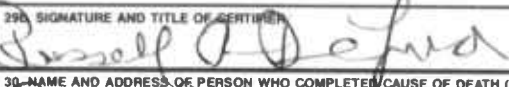
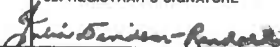
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30210

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY K. BROWN				2. DATE OF DEATH MONTH DAY YEAR OCT 10 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-14-0864		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 6, 1916	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) 107 AMESBURY COURT		9b. CITY, TOWN OR LOCATION OF DEATH SEVERNA PARK	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION SEVERNA PARK				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 297 TOLSTOY LANE	
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) ROBERT REED KIRBY				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA VIRGINIA MOSSBURGER			
19a. INFORMANT'S NAME (Type/Print) Mr. Robert K. Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Amesbury Court, Severna Park, MD 21146			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. 10/12		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, MD 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 30 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Russell R. Deluca				29c. LICENSE NUMBER 051751		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Russell R. Deluca MD, 1600 Crain Highway, Suite 496, Glenview, IL 60025							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30211

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter Boyd				2. DATE OF DEATH MONTH DAY YEAR October 11 1994		3. TIME OF DEATH 5:00 a.m.	
4. SOCIAL SECURITY NUMBER 216-32-3164		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-22-1938	
8. BIRTHPLACE (State or Foreign Country) S. Carolina				9a. FACILITY NAME (If not institution, give street and number) Gift of Hope/Missionaries of Charity		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md		10b. COUNTY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 818 North Collington Ave.	
10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer	
16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown		19a. INFORMANT'S NAME (Type/Print) Sr. Pietra	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 N. Collington Ave. Baltimore, Md. 21205		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Carmel Cemetery 10-14		20c. LOCATION — City or Town, State Baltimore City	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HIV-related cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. HIV infection DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 months 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal insufficiency, w/o endocarditis, w/o epidural abscess, w/o septic arthritis							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joe J. Gallant MD</i>				29c. LICENSE NUMBER D38398		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joe J. Gallant, MD 1830 E. Monument St, Ste 7401, Baltimore, MD 21205							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE <i>John Benjamin-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30212

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MERRY E. BRITT				2. DATE OF DEATH MONTH OCT. DAY 12 YEAR 1994		3. TIME OF DEATH 6:50 P M	
4. SOCIAL SECURITY NUMBER 462-70-4356		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 25 1944	
8a. FACILITY NAME (If not institution, give street and number) 5247 LIGHTFOOT PATH				8b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		8c. COUNTY OF DEATH HOWARD	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION COLUMBIA		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5247 LIGHTFOOT PATH				10f. ZIP CODE 21044		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN - NURSE		16b. KIND OF BUSINESS/INDUSTRY HEALTH FIELD			
17. FATHER'S NAME (First, Middle, Last) NATHANIEL RAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ODESSA BROTHERS			
19a. INFORMANT'S NAME (Type/Print) MICHAEL BRITT (HUSBAND)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5247 LIGHTFOOT PATH, COLUMBIA, MD. 21044			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		DATE OCT. 15 1994		20c. LOCATION — City or Town, State CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY LEROY & RUSSELL WITZKE FUNERAL HOME 5555 TWIN KNOLLS RD. COLUMBIA, MD. 21045			
23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. multiple myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER D 30928		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY BERG, M.D. TWO KNOLL NORTH COLUMBIA, MD 21044							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: And the funeral director has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Deondra Nykea Harper			2. DATE OF DEATH MONTH SEPTEMBER DAY 29 YEAR 1994		3. TIME OF DEATH 12:04 a.m.
4. SOCIAL SECURITY NUMBER BABY			5. SEX GIRL		6. AGE (In yrs. last birthday) GOATES
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH Maryland
RESIDENCE OF DECEDENT					
10a. STATE MD		10b. COUNTY BALTIMORE, MARYLAND		10c. CITY, TOWN OR LOCATION BALTIMORE, MARYLAND	
10d. INSIDE CITY LIMITS? 1 X YES 2 NO		10e. STREET AND NUMBER 1645 N. CALHOUN STREET		10f. ZIP CODE 21217	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 X Never Married 2 Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	
16. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) CALVIN HARPER		18. MOTHER'S NAME (First, Middle, Maiden Surname) DONDRA COATES	
19a. INFORMANT'S NAME (Type/Print) DONDRA COATES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1645 N. CALHOUN STREET-BALTIMORE, MD. 21217			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JHM 9/29/94		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHNS HOPKINS HOSPITAL		22. NAME AND ADDRESS OF FACILITY 600 N. WOLFE STREET			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. pulmonary hypoplasia DUE TO (OR AS A CONSEQUENCE OF): b. severe oligohydramnios DUE TO (OR AS A CONSEQUENCE OF): c. prematurity DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death 12 hours 12 hours 12 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 YES 2 NO	
28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Joseph J. Zorc, M.D.		29c. LICENSE NUMBER 184370		29d. DATE SIGNED (Month, Day, Year) 9/29/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Joseph J. Zorc, M.D. Dock & Lounge Johns Hopkins Hosp Baltimore, MD 21239					
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE Julia A. ...			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30214

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Nancy Camp</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>13</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1:45 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-62-6963</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8-5-24</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Md.</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>417 Edgewood St.</i>				10f. ZIP CODE <i>21229</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Foster Rodgers</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah Gee Coleman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Wendell Camp</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>417 Edgewood St., Balto., Md. 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley</i>		DATE <i>10/18</i>		20c. LOCATION — City or Town, State <i>Towson, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <i>James A. Morton & Sons, F. H. Inc 1701 Laurens St. Balto., Md. 21217</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Asystolic Arrest</i> Due to (or as a consequence of): <i>Hyperkalemia</i> Due to (or as a consequence of): <i>Metabolic Acidosis</i> Due to (or as a consequence of): <i>End stage renal disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>peripheral vascular disease hypertension, diabetes mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deborah S. Hopkins MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>10/13/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Deborah S. Hopkins, University Hospital, 225. Greene St., Baltimore, MD</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 14 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


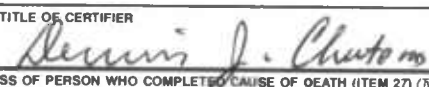
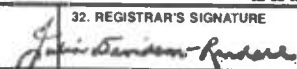
94-5871-510

blh

94 30215

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Scott Frederick Castleberry				2. DATE OF DEATH MONTH DAY YEAR Oct 13 1994		3. TIME OF DEATH M 0130	
4. SOCIAL SECURITY NUMBER 218-82-4612		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/9/1962	
9a. FACILITY NAME (If not institution, give street and number) 1200 blk. Bush Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH -----	
10a. STATE Maryland		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Balto. City, Md.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 601 E. Clement St.				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chef		16b. KIND OF BUSINESS/INDUSTRY Clement St. Cafe			
17. FATHER'S NAME (First, Middle, Last) Jimmy C. Castleberry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor M. Berkenkemper			
19a. INFORMANT'S NAME (Type/Print) Mr. Jimmy C. Castleberry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 E. Clement St. Balto. Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Cedar Hill Cemetery, 10/17/94		20c. LOCATION — City or Town, State A.A. Co. Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound to Back of Chest DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-13-94		28b. TIME OF INJURY 1:20 A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street		28e. DESCRIBE NOW INJURY OCCURED Subject shot			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1200 Block Bush St Baltimore, Md					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Oct 13 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30216

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS P. DONOVAN				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 94		3. TIME OF DEATH 0800 a.	
4. SOCIAL SECURITY NUMBER 053-21-5001		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-18-33	
9a. FACILITY NAME (If not Institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE		10c. CITY, TOWN OR LOCATION BOWIE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4408 ORLAN LANE				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES		16b. KIND OF BUSINESS/INDUSTRY AIR CONDITIONING CO.			
17. FATHER'S NAME (First, Middle, Last) JAMES DONOVAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARION			
19a. INFORMANT'S NAME (Type/Print) ELIZABETH DONOVAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 ORLAN LANE, BOWIE, MD. 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. PLEASANT CEMETERY 10-18-94		20c. LOCATION — City or Town, State FAIRPORT, NEW YORK			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phyllis Stahl</i> MOO550				22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Metastatic colon cancer							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D30802		29d. DATE SIGNED (Month, Day, Year) 10-13-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jean M. Colandrea, M.D. - St. Agnes Hospital - 900 Caton Ave. Balto., Md. 21229							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30217

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lillian M. Deickman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>October 11, 1994</i>		3. TIME OF DEATH M <i>M</i>	
4. SOCIAL SECURITY NUMBER <i>163-24-8201</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>06/15/1914</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>Maryland</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Fort Howard</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>9418 Todd Avenue</i>		10f. ZIP CODE <i>21052</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i> College (1-4 or 5+) <i>College</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Cashier</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Retail</i>		17. FATHER'S NAME (First, Middle, Last) <i>(Unknown) Thoman</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>(Unknown)</i>				19a. INFORMANT'S NAME (Type/Print) <i>Mr. Harold Screen</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2804 Munster Road Baltimore, Maryland 21234</i>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Louisa Park Cemetery 10/14/94</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. L...</i>				22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>CORONARY ARTERY DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. ...</i>				29c. LICENSE NUMBER <i>1025003</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/12/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>4940 WASHINGTON BLVD BALTIMORE 21224</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 14 1994</i>		32. REGISTRAR'S SIGNATURE <i>John J. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30218

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harriette R. Eaton				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-05-5533		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) 2-05-08				8. BIRTHPLACE (State or Foreign Country) Md.			
9a. FACILITY NAME (If not institution, give street and number) Inns of Evergreen				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1430 McCulloh St.				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY Balto. County			
17. FATHER'S NAME (First, Middle, Last) Royal P. Stark				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sylvia E. Stark			
19a. INFORMANT'S NAME (Type/Print) Evassar Eaton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1430 McCulloh St. Balto., Md. 21217			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Park		DATE 10/18		20c. LOCATION — City or Town, State Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dehydration DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Quadraplegia, Dementia, Depression							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Debrah Morris MD				29c. LICENSE NUMBER D31364		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21 Crossroads A, #250 Owings Mills, MD 21117							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John Sanborn-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

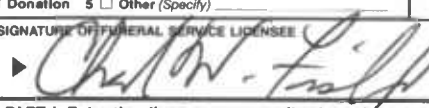


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30219

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clifton EDENTON				2. DATE OF DEATH MONTH DAY YEAR October 8, 1994		3. TIME OF DEATH A M 3:35 A	
4. SOCIAL SECURITY NUMBER 213-28-6396		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04/03/1931	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Edgemere		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8000 Dogwood Road Lot #11				10f. ZIP CODE 21219		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steelworker		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp.			
17. FATHER'S NAME (First, Middle, Last) Edenton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Hairfield			
19a. INFORMANT'S NAME (Type/Print) Mrs. Pauline Edenton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Dogwood Road Lot #11 Edgemere, MD 21219			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 10/8/94		20c. LOCATION — City or Town, State Towson, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Bronchogenic Cancer Right Pneumonectomy DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Post Operative Atrial Fibrillation							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D34837		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel Harley, MD 9105 Franklin Square Drive Suite 217 Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GRACE MARIE FABER				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 2:15 A. M	
4. SOCIAL SECURITY NUMBER 219-01-6659		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 17 1905	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION 21207		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 942 ST. AGNES LANE				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY DEPARTMENT STORES			
17. FATHER'S NAME (First, Middle, Last) FRANK VENDITTI				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE TOSKES			
19a. INFORMANT'S NAME (Type/Print) PALMA FABER (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 ST. AGNES LANE BALTIMORE, MARYLAND 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CEMETERY 10-15-94		20c. LOCATION — City or Town, State BALTIMORE MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Pulmonary Arrest							
Due to (or as a consequence of): Stroke							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							
Parkinsonism							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER N. B. VELLANKI, MD.				29c. LICENSE NUMBER D30469.		29d. DATE SIGNED (Month, Day, Year) 10-11-1994.	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042.							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 23 (Underlying Cause of Death) or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30221

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen</i> HELEN GRAHAM <i>Graham</i>				2. DATE OF DEATH MONTH: 11 DAY: 11 YEAR: 1994		3. TIME OF DEATH 6:45 P M	
4. SOCIAL SECURITY NUMBER 218-01-0832		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 6, 1912	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Joseph Richey Hospice		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 201 N. Washington Street Apt. 512	
10f. ZIP CODE 21231				10g. CITIZEN OF WHAT COUNTRY? U. S. A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Manager		16b. KIND OF BUSINESS/INDUSTRY Balto. City Ed. Dept.	
17. FATHER'S NAME (First, Middle, Last) Oscar Harris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Williams			
19a. INFORMANT'S NAME (Type/Print) Dorothy Diggs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 N. Durham Street, Baltimore, MD 21213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 5/15		20c. LOCATION — City or Town, State Woodlawn, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Blair Adams Jones</i>				22. NAME AND ADDRESS OF FACILITY Marshall W. Jones, Jr. Funeral HM PA 4101 Edmondson Ave. Baltimore, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Respiratory Arrest</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Pulmonary Disease</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Carcinoma Lung</i> d. Approximate Interval Between Onset and Death <i>minutes</i> <i>1 yr.</i> <i>4 yrs.</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension.</i> <i>Paget's Disease.</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. Irwin MD</i>				29c. LICENSE NUMBER D08900		29d. DATE SIGNED (Month, Day, Year) 10-12-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert C. Irwin MD</i> 828 N. Gilman St. Baltimore MD 21201.							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John Borden</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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15551

RECEIVED
JAN 10 1900

RECEIVED
JAN 10 1900

94 30222

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN A. GERCHMAN				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 218-12-6552		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-10-21	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) 2350 Eldeberry Lane		9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Reisterstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2350 Eldeberry Lane-	
10f. ZIP CODE 21136				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES N/A				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) August Lemm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Gaubatz			
19a. INFORMANT'S NAME (Type/Print) Robert F. Gerchman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2350 Eldeberry Ln.-Reisterstown, Md. 21136			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Laudon Park Mausoleum 10-15-94-Balto., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Baltimore, Md. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Flavio Kruter MD				29c. LICENSE NUMBER D35378		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FLAVIO KRUTER, MD - 904 WASHINGTON RD SE D - WASHINGTON, MD 21132							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE Julia S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30223

Item 10c, d, e, f, Item 11, File 716, 10/14/94, 1t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelina Greene				AKA Evelina Marie Greene				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 8:50 pm			
4. SOCIAL SECURITY NUMBER 008-14-2935		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) 6-28-22			
8. FACILITY NAME (If not institution, give street and number) Mercy Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore MD				9c. COUNTY OF DEATH NA					
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION (Brooklyn Park) BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 7363 E. SETAM Road				10f. ZIP CODE 21849 21061				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian & Maintenance				16b. KIND OF BUSINESS/INDUSTRY Glen Burnie High School					
17. FATHER'S NAME (First, Middle, Last) John Noyes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelina Elizabeth ---									
19a. INFORMANT'S NAME (Type/Print) Mr. Robert Preston Greene				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Castle Road, Glen Burnie, Maryland 21061									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/14/94				20c. LOCATION — City or Town, State Catonsville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore, Md. 21225									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Rectal Carcinoma with Metastases DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): d. Aspiration Pneumonia										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Thymis A. Moody MD								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/11/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Glynis A. Moody, MD Mercy Medical Center Baltimore, MD													
31. DATE FILED OCT 14 1994				32. REGISTRAR'S SIGNATURE James R. Anderson									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30224

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edna Gross				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 1505 M	
4. SOCIAL SECURITY NUMBER 218-03-7641		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH 3-17-04	
8a. FACILITY NAME (If not institution, give street and number) Deaton Specialty Hospital and Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland				9c. COUNTY OF DEATH MD.	
10a. STATE MD.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 601 S. Charles St.				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 5 th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) UNK.				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNK.			
19a. INFORMANT'S NAME (Type/Print) Sunni A. Hasan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Exeter Hall Ave. Baltimore, MD. 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cem 10-15-94		20c. LOCATION — City or Town, State Lansdowne, MD.		20d. DATE 10-15-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/HPa 638 N. Gilmor St, 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Gangrenous Foot DUE TO (OR AS A CONSEQUENCE OF): Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death Days Days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration Pneumonia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER MD		29c. LICENSE NUMBER D38675		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JDEL MESHULAM 1147 S HANOVER ST BALT MD 21230							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPT 11 139

94 30225

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT LEE GRIFFIN				2. DATE OF DEATH MONTH 10 DAY 7 YEAR 94		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 216-68-5249		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-11-56	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Springfield Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland			
10b. COUNTY Carroll County				10c. CITY, TOWN OR LOCATION Sykesville			
10d. INSIDE CITY LIMITS? 1 YES 2 X NO				10e. STREET AND NUMBER Springfield Hospital Center			
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY Westinghouse			
17. FATHER'S NAME (First, Middle, Last) Robert L. Griffin, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Howard			
19a. INFORMANT'S NAME (Type/Print) Springfield Hospital				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sykesville, Maryland 21784			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springfield Cemetery 10/8/94		20c. LOCATION — City or Town, State Sykesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight		22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UPPER GASTROINTESTINAL BLEEDING DUE TO (OR AS A CONSEQUENCE OF): b. LIVER FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): d. HUMAN IMMUNODEFICIENCY VIRUS INFECTION Approximate Interval Between Onset and Death DAYS YEARS YEARS YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Martin Magran				29c. LICENSE NUMBER D15540		29d. DATE SIGNED (Month, Day, Year) 10-7-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN MAGRAN 6565 N. CHARLES STREET SUITE 210 BALT. MD. 21204							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

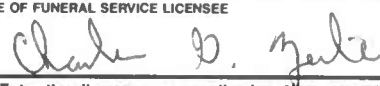
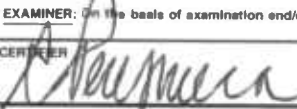
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30226

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Albert Dewey Huling				2. DATE OF DEATH 10 MONTH 12 DAY 94 YEAR		3. TIME OF DEATH 9:33 A M	
4. SOCIAL SECURITY NUMBER 415 03 6887		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08 07 07	
8. BIRTHPLACE (State or Foreign Country) Tenn.				9a. FACILITY NAME (If not institution, give street and number) Hopkins Bay View Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10. RESIDENCE OF DECEDENT			
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 428 Folcroft Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Vulcan-Hart			
17. FATHER'S NAME (First, Middle, Last) James Huling				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora			
19a. INFORMANT'S NAME (Type/Print) Goldie E. Huling				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Folcroft St. Balto., Md. 21224			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10-15-94		20c. LOCATION — City or Town, State Middle River, Md		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary hypertension, advanced Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29a. SIGNATURE AND TITLE OF CERTIFIER 				29b. LICENSE NUMBER D10613		29c. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 14 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30227

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Virginia HARDESTY				2. DATE OF DEATH MONTH DAY YEAR October 11, 1994		3. TIME OF DEATH 10:13 a M	
4. SOCIAL SECURITY NUMBER 219-20-6790		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-11-1916	
8. BIRTHPLACE (State or Foreign Country) West Virginia							
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 115 Dihedral Drive				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PLant Work		16b. KIND OF BUSINESS/INDUSTRY Aircraft Co.			
17. FATHER'S NAME (First, Middle, Last) Oscar Scarff		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Brown					
19a. INFORMANT'S NAME (Type/Print) Blair Hardesty				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Dihedral Dr., Essex, Md. 21220			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GreenMount Crematory 10-12 94 Balto., Md.		20c. LOCATION — City or Town, State 21222		22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins <i>Edison M. Perkins</i>		21a. D00083					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End Stage Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 20 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Coronary Artery Disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marie Chatham</i>				29c. LICENSE NUMBER p20907		29d. DATE SIGNED (Month, Day, Year) October 11, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marie Chatham 9000 Franklin Square Drive Baltimore, Md 21237							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ALONZO JACKSON		2. DATE OF DEATH MONTH DAY YEAR OCT. 11 1994		3. TIME OF DEATH 10:50 A M	
4. SOCIAL SECURITY NUMBER 219-20-5518		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 3-4-10		8. BIRTHPLACE (State or Foreign Country) D.C.			
9a. FACILITY NAME (If not institution, give street and number) 716 WASHINGTON PLACE APT 305		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 16 Washington St.		10f. ZIP CODE 21201	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) College	
16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) Unk.	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Duckett		19a. INFORMANT'S NAME (Type/Print) Robert E. Stewart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Westwood Ave Baltimore, MD 21216	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cem, 10-14-94 Lansdowne, MD.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H pa 638 N. Gilmore St. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Had only		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) 10/12/1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maryann A. Koron 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30229

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eugene F. Kraus				2. DATE OF DEATH MONTH DAY YEAR Oct. 12, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-30-4968		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 27, 1933 PA.	
9a. FACILITY NAME (If not institution, give street and number) 614 Lanoitan Road				9b. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 614 Lanoitan Road Apt. J				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Md. State Police		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Peter John Kraus				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Sakulsky			
19a. INFORMANT'S NAME (Type/Print) Vera Stricker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Silver Maple Court Baltimore Md. 21220			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 10/14/94 Baltimore MD.		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DM DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10min 15 yrs 15 yrs.						PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William E. Swan				29c. LICENSE NUMBER D44604		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 14 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30230

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George H. Knight, Jr.				2. DATE OF DEATH MONTH DAY YEAR October 7, 1994		3. TIME OF DEATH M <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	
4. SOCIAL SECURITY NUMBER 212 20 3042		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 14, 1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Anne Arundel			
10. FACILITY NAME (If not institution, give street and number) 7531 Rock Creek Way				11. CITY, TOWN OR LOCATION OF DEATH Pasadena		12. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
13. STATE Maryland				14. COUNTY Anne Arundel		15. CITY, TOWN OR LOCATION Pasadena	
16. STREET AND NUMBER 7531 Rock Creek Way				17. ZIP CODE 21122		18. CITIZEN OF WHAT COUNTRY? United States	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: White	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Business Agent		25. KIND OF BUSINESS/INDUSTRY Union Local #100			
26. FATHER'S NAME (First, Middle, Last) George H. Knight, Sr.				27. MOTHER'S NAME (First, Middle, Maiden Surname) Sara Schreck			
28. INFORMANT'S NAME (Type/Print) Alma L. Knight				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7531 Rock Creek Way, Pasadena, MD 21122			
30. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 10/10/94		32. LOCATION — City or Town, State Baltimore, MD		33. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
34. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122				35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> <i>Hypertension</i>			
36. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Arrest</i>				37. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>End Stage Abdominal Disease</i> <i>Heart failure</i>			
38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				39. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
43. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		44. 28a. DATE OF INJURY (Month, Day, Year)		45. 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		46. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
47. 28d. DESCRIBE HOW INJURY OCCURRED		48. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		49. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
50. 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				52. 29c. LICENSE NUMBER D22028		53. 29d. DATE SIGNED (Month, Day, Year) 10/7/94	
54. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
55. 31. DATE FILED (Month, Day, Year) OCT 14 1994				56. 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

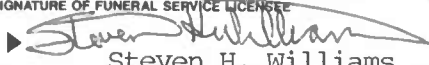
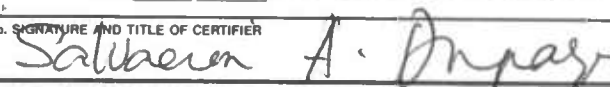
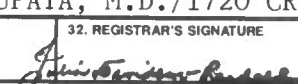
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30231

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK J. KUZMA Sr.				2. DATE OF DEATH MONTH DAY YEAR 10 06 94		3. TIME OF DEATH 11:16 PM M	
4. SOCIAL SECURITY NUMBER 213-40-0588		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG 05, 1905	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 25 Nicholson Drive				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sanitation Attendant		16b. KIND OF BUSINESS/INDUSTRY Baltimore City			
17. FATHER'S NAME (First, Middle, Last) John Kuzma				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susanna (unknown)			
19a. INFORMANT'S NAME (Type/Print) Mr. Roaland Cross				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Nicholson Drive Pasadena, MD 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 10/10		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, MD 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cardiac Arrest</i>					
		b. <i>Atherosclerotic Heart Disease</i>					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Salvia A. Dupaya				29c. LICENSE NUMBER D38912		29d. DATE SIGNED (Month, Day, Year) 10/09/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IF EM 27) (Type, Print) SALVACION A. DUPAYA, M.D./1720 CRAIN HWY, S #204/GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30232

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elroy Arte Klapp				2. DATE OF DEATH MONTH DAY YEAR 10/13/94		3. TIME OF DEATH 3 A. M	
4. SOCIAL SECURITY NUMBER 218 40 2606		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/13/42	
9a. FACILITY NAME (If not institution, give street and number) 633 Hoods Mill Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Woodbine		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY C arroll		10c. CITY, TOWN OR LOCATION Woodbine		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 633 Hoods Mill JRd.				10f. ZIP CODE 21797		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES Army 1961		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H.S.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Construc tion			
17. FATHER'S NAME (First, Middle, Last) Earl P. Klapp				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madeline R. Klapp			
19a. INFORMANT'S NAME (Type/Print) Melanie E. Wilson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Hoods Mill Rd. Woodbine, Md. 21797			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Highland View Cemetery 10/15/94 Sykesville, Md		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF):					
		b. Systemic Amyloidosis DUE TO (OR AS A CONSEQUENCE OF):					
		c. Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 6 months 2 months 2 months					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D42979		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 North Wolfe St Baltimore MD 21287							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30233

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOWARD FREDERICK LEHNERT, SR.				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1994				3. TIME OF DEATH 7:30 A. M.				
4. SOCIAL SECURITY NUMBER 216-24-4926		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 30, 1930		8. BIRTHPLACE (State or Foreign Country) BALTO., MD	
9a. FACILITY NAME (If not institution, give street and number) 5840 SHADYSIDE ROAD					9b. CITY, TOWN OR LOCATION OF DEATH SHADYSIDE				9c. COUNTY OF DEATH ANNE ARUNDEL			
RESIDENCE OF DECEDENT												
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SHADYSIDE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5840 SHADYSIDE ROAD					10f. ZIP CODE 20764			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7TH GRADE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONTRACTOR				16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION				
17. FATHER'S NAME (First, Middle, Last) WILLIAM FREDERICK LEHNERT						18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE HELEN SACHS						
19a. INFORMANT'S NAME (Type/Print) MRS. DORIS A. LEHNERT					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5840 SHADYSIDE ROAD - SHADYSIDE, MD. 20764							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY				DATE 10/15		20c. LOCATION — City or Town, State BALTIMORE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stuart E. Selouch</i>					22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → colonic carcinoma Approximate Interval Between Onset and Death 2 yrs												
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart E. Selouch, M.D.</i>						29c. LICENSE NUMBER 019838		29d. DATE SIGNED (Month, Day, Year) 10/13/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart E. Selouch, M.D. 900 Restgate Annapolis Md. 21401												
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


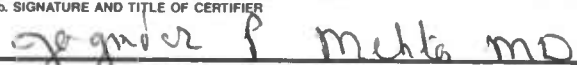
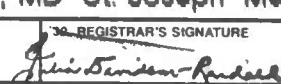
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30234

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances				2. DATE OF DEATH MONTH Oct DAY 13 YEAR 1994				3. TIME OF DEATH 1:40 am	
4. SOCIAL SECURITY NUMBER 213-46-2481		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 9, 09		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland				9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore, City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4610 Parkwood AVE.				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Saverio Cortez				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Possidenti					
19a. INFORMANT'S NAME (Type/Print) Michael J. Cortez				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 West 23rd Street 21211					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 10/15/94		20c. LOCATION — City or Town, State Balto. Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd. 21214					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. UROSEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Dehydration DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 3 DAYS 3 years 3 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Ventricular Arrhythmia								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Joginder P. Mehta MD		29c. LICENSE NUMBER D41410		29d. DATE SIGNED (Month, Day, Year) 10-13-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joginder P. Mehta, MD St. Joseph Medical Center, Towson, MD 21204									
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30235

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PURNELL LANAHAN				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 7:30 P. M.	
4. SOCIAL SECURITY NUMBER 219-05-7141		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-19-12	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) COLLEGE MANOR NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH LUTHERVILLE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION LUTHERVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 300 WEST SEMINARY AVENUE	
10f. ZIP CODE 21093				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DANCER		16b. KIND OF BUSINESS/INDUSTRY ENTERTAINMENT			
17. FATHER'S NAME (First, Middle, Last) HORATIO MATHIAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNY GERMAN			
19a. INFORMANT'S NAME (Type/Print) ARTHUR DRAGER (ATTORNEY)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LIGHT STREET SUITE 510 BALTIMORE, MARYLAND 21202			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY 10-14-94		20c. LOCATION — City or Town, State WOODLAWN MARYLAND		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Exacerbation of Chronic Obstructive Pulmonary Disease Approximate Interval Between Onset and Death: 1 week Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) College Manor					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER 024732		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. T. Souweine MD 1134 Gough Rd Towson, Md							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30236

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN E. MCCORMICK				2. DATE OF DEATH MONTH Oct DAY 12 YEAR 1994		3. TIME OF DEATH 12:15 pm	
4. SOCIAL SECURITY NUMBER 219-32-6060		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-12-35	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore							
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2719 Louise Ave.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1958-59		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shoe Design		16b. KIND OF BUSINESS/INDUSTRY Self	
17. FATHER'S NAME (First, Middle, Last) Edgar McCormick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Fentitta			
19a. INFORMANT'S NAME (Type/Print) Mrs. Judith A. McCormick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2719 Louise Ave. Balto., Md. 21214			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Mem. Cem. 10/15 Balto., Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jody Smith				22. NAME AND ADDRESS OF FACILITY Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LIVER METASTASIS DUE TO (OR AS A CONSEQUENCE OF): b. High grade unilateral Ca of renal pelvis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
Approximate Interval Between Onset and Death 1 WK 8 mo							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Arthur A. Serpick				29c. LICENSE NUMBER D 16091		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARTHUR A. SERPICK, M.D., 7620 YORK RD., TOWSON, MD. 21204							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30237

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alberta MESSENGER				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 8:26 A M		
4. SOCIAL SECURITY NUMBER 217-03-3215		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH MONTH 01 DAY 14 YEAR 1915		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore		
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 2206 Souththorn Road				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Martin Marietta				
17. FATHER'S NAME (First, Middle, Last) Grover Cleveland Jackson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Myrtle Jackson				
19a. INFORMANT'S NAME (Type/Print) Charles Messenger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Old Harford Road Baltimore Md. 21234				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10/15/94 Baltimore MD.		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connolly</i>				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Cerebral infarct DUE TO (OR AS A CONSEQUENCE OF): Anterior communicating artery aneurysm DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 12 days 12 days								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Abbasi</i>		29c. LICENSE NUMBER n/a		29d. DATE SIGNED (Month, Day, Year) 10.12.94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mustafa Abbasi, MD, 9000 Franklin Square Drive Baltimore, MD 21237								
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. SIGNATURE OF REGISTRAR <i>John H. Davidson</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>James McNeill</u> McNeill				2. DATE OF DEATH MONTH <u>10</u> DAY <u>11</u> YEAR <u>94</u>		3. TIME OF DEATH <u>3:35 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>468-52-8909</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>47</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8-24-47</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>BALTIMORE VA MEDICAL CENTER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>10 NORTH GREENE STREET</u>				10f. ZIP CODE <u>21201</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>VIETNAM WAR</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>DISABLED</u>		16b. KIND OF BUSINESS/INDUSTRY <u>N/A</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOHN E. MCNEILL</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>PATRICIA MCCALLISTER</u>			
19a. INFORMANT'S NAME (Type/Print) <u>ALIXE MCNEILL</u> John D. McNeill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11105 Bluestem Lane, Eden Prairie, MN 55347</u>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Resurrection Cemetery</u> <u>10/15</u>		20c. LOCATION — City or Town, State <u>Mendota Hts. MN</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Phillips</u> MO0550		22. NAME AND ADDRESS OF FACILITY <u>STERLING ASHTON FUNERAL HOME, INC.</u> <u>736 EDMONDSON AVE., BALTIMORE, MD, 21228</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Liver Failure</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>Alcohol abuse</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>1 month</u> <u>years</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> <u>Candida peritonitis</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Marshall</u>				29c. LICENSE NUMBER <u>D35363</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/11/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>S. Marshall</u> <u>Baltimore VA Medical Center 10 N. Greene St. Baltimore, Md. 21201</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 14 1994</u>				32. REGISTRAR'S SIGNATURE <u>John A. ...</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30239

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie H Meiser				2. DATE OF DEATH MONTH DAY YEAR 10 06 1994		3. TIME OF DEATH 1:33 P M	
4. SOCIAL SECURITY NUMBER 216-36-9959		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-22-1912	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Hartley Hall Nursing home, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Pocomoke City	
9c. COUNTY OF DEATH Worcester				10a. STATE Virginia		10b. COUNTY Accomack	
10c. CITY, TOWN OR LOCATION Greenbackville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2122 Buckaneer Blvd. Captain's Cove	
10f. ZIP CODE 23356				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator		16b. KIND OF BUSINESS/INDUSTRY Telephone Company	
17. FATHER'S NAME (First, Middle, Last) William Mc Cabe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Helsby			
19a. INFORMANT'S NAME (Type/Print) Mrs. Vickie Sell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Mulberry Ridge Court Pasadena, MD. 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 10/10/94		20c. LOCATION — City or Town, State Glen Burnie, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Volmer L. Polynick</i>				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Squamous Cell Carcinoma of Anus, Advanced</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multiple CVA</i> <i>Multi-Infarct Dementia</i> <i>Hypertension</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. D.</i>				29c. LICENSE NUMBER D-29505		29d. DATE SIGNED (Month, Day, Year) 10-6-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D.; 4421 BEECHWOOD PL., CRISFIELD, MD 21817							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29b is signed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

STUDY OF THE
EFFECTS OF
THE
CHICAGO
FIRE
ON
THE
CITY


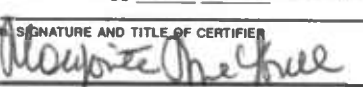

(1)

94 30240

ITEMS: 23 PART I, 27, 28a,b,d,e,f, PER MEO FILM G-716 10/28/94 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FREDERICK JAMES MULLEN				ANA Mullen Frederick James				2. DATE OF DEATH MONTH DAY YEAR OCT. 09, 1994				3. TIME OF DEATH 21:27 P M			
4. SOCIAL SECURITY NUMBER 220-74-2606				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/14/1957		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 1521 CLARKSON ST.								9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH -----			
10a. STATE Maryland				10b. COUNTY -----				10c. CITY, TOWN OR LOCATION Balto. City, Md.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1521 Clarkson St.								10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES: _____				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 9th Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Printing Press				16b. KIND OF BUSINESS/INDUSTRY Printing Factory							
17. FATHER'S NAME (First, Middle, Last) Charles Edward Mullen, Jr.								18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Ruth Cody							
19a. INFORMANT'S NAME (Type/Print) Mr. Charles E. Mullen								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1532 Clarkson St. Balto. Md. 21230							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Meadowridge Mem. Park, 10/13/				20c. LOCATION — City or Town, State Md. Elkridge, Howard Co.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCULLY Funeral Home, 130 E. Fort Av							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. NARCOTIC, COCAINE AND PHENCYCLIDINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) FOUND: 10-9-94		28b. TIME OF INJURY FOUND: 9:20 P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1521 CLARKSON STREET BALTIMORE CITY							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) OCT. 10, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGARET A. KOENIG 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30241

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Timothy M. McGarry				2. DATE OF DEATH MONTH DAY YEAR Oct. 12, 1994		3. TIME OF DEATH 10 A. M.	
4. SOCIAL SECURITY NUMBER 217 38 1104		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/30/40	
9a. FACILITY NAME (If not institution, give street and number) 5204 Gate House Court				9b. CITY, TOWN OR LOCATION OF DEATH Sykesville		9c. COUNTY OF DEATH Carroll	
10a. STATE Md.				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Sykesville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 5204 Gate House Court			
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) H.S.		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Operator		16b. KIND OF BUSINESS/INDUSTRY Lever Brothers			
17. FATHER'S NAME (First, Middle, Last) Timothy Thomas McGarry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Josephine Day			
19a. INFORMANT'S NAME (Type/Print) Joyce M. McGarry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5204 Gate House Ct. Sykesville, Md. 21784			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park 10/14/94 Sykesville, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home d.p.o. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lin P. M. M.D.				29c. LICENSE NUMBER 034406		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richmond P. Allan, 1645 Liberty Rd., Eldersburg, MD							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30242

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Ray McElroy				2. DATE OF DEATH MONTH DAY YEAR October 11, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 220-16-2365		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1906	
9a. FACILITY NAME (If not institution, give street and number) 7432 Spout Hill Road				9b. CITY, TOWN OR LOCATION OF DEATH Sykesville		9c. COUNTY OF DEATH Carroll County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll County		10c. CITY, TOWN OR LOCATION Sykesville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7432 Spout Hill Road				10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Worker		16b. KIND OF BUSINESS/INDUSTRY Town of Sykesville			
17. FATHER'S NAME (First, Middle, Last) James Waldo McElroy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Rogers			
19a. INFORMANT'S NAME (Type/Print) Mrs. Frankie Wilcox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7432 Spout Hill Road Sykesville, MD 21784			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springfield Cemetery 10/15/94 Sykesville, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Cardiac Death Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): ASCLVD c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death seconds
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, Bowers' Disease, Benign Prostatic Hypertrophy							24a. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. McElroy, MD				29c. LICENSE NUMBER D33681		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. McElroy, MD 7540 COLLEGE AVE SYKESVILLE MD 21784							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30243

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM JAMES PARRISH				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 11:05 PM		
4. SOCIAL SECURITY NUMBER 159-03-5392		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-9-1911		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY		
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 300 Georgia Avenue,				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Superintendant		16b. KIND OF BUSINESS/INDUSTRY Construction Co.				
17. FATHER'S NAME (First, Middle, Last) Ellsworth Parrish				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Lowe				
19a. INFORMANT'S NAME (Type/Print) Mr. Robert Parrish				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1426 Locust St., Baltimore, Maryland 21226				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olive U. Methodist Cem.		DATE 10/15		20c. LOCATION — City or Town, State Randallstown, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → probable cardiac arrhythmia minutes DUE TO (OR AS A CONSEQUENCE OF): Respiratory failure days DUE TO (OR AS A CONSEQUENCE OF): aspiration pneumonia days DUE TO (OR AS A CONSEQUENCE OF): brainstem cerebrovascular accident week Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER James E. Skarbek, M.D.				29c. LICENSE NUMBER 029767		29d. DATE SIGNED (Month, Day, Year) 10/12/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JERRY D. SKARBEK, M.D./8418 BALTIMORE-ANNAPOLIS BLVD/PASADENA, MARYLAND 21122								
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John D. Anderson				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28a marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30244

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHARINE HOOPER PIERCE			2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 11:00 P. M.
4. SOCIAL SECURITY NUMBER 218-12-4021	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12-12-1897	8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not Institution, give street and number) CHARLESTOWN CARE CENTER			9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY BALTIMORE	10c. CITY, TOWN OR LOCATION CATONSVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 711 MAIDEN CHOICE LANE		10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY DOMESTIC	
17. FATHER'S NAME (First, Middle, Last) GORDON BENSON SNELLING			18. MOTHER'S NAME (First, Middle, Maiden Surname) LIZZIE BELL DIVEN		
19a. INFORMANT'S NAME (Type/Print) DOSWELL MORFOOT (DAUGHTER)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 MAIDEN CHOICE LANE CATONSVILLE MARYLAND 21228		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY 10-14-94		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>B. C. Witke</i>		22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Pneumonia, aspiration</i> DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <i>day</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>stroke</i> DUE TO (OR AS A CONSEQUENCE OF):		<i>day</i>	
		c. <i>arteriosclerotic cardiovascular</i> DUE TO (OR AS A CONSEQUENCE OF):		<i>year</i>	
		d. <i>sepsis</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laurence R. Gallager, M.D.</i>			29c. LICENSE NUMBER D 01786		29d. DATE SIGNED (Month, Day, Year) 10/13/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laurence R. Gallager, M.D. 3455 Wilkens Avenue Baltimore, Maryland 21229					
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE <i>John Sanborn-Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 24 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30245

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William, Rigler</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>11</i> YEAR <i>94</i>		3. TIME OF DEATH <i>7:20 P. M.</i>	
4. SOCIAL SECURITY NUMBER <i>21507-4809</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 24, 1918</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9. COUNTY OF DEATH -----			
9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH -----	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7 Troon Court</i>				10f. ZIP CODE <i>21236</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Self-Employed</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Food Service</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William McKinley Rigler</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mildred Lewis Crawford</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Helen Rigler (wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7 Troon Court, Baltimore, MD 21236</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hampstead Cemetery</i>		DATE <i>10/14</i>		20c. LOCATION — City or Town, State <i>Hampstead, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute MI</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] physician</i>				29c. LICENSE NUMBER <i>D40611</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/11/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Church Hospital (Alan Schneider) Balt MD</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 14 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2012

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Oct 14 1930

94 30246

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret C. Ritger				2. DATE OF DEATH MONTH DAY YEAR Oct. 13, 1994		3. TIME OF DEATH 4:30 p.m.	
4. SOCIAL SECURITY NUMBER 220-20-9941		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 25, 1902		8. BIRTHPLACE (State or Foreign Country) Georgia	
9a. FACILITY NAME (If not institution, give street and number) 7424 Old Battle Grove Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7424 Old Battle Grove Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George Bush				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Bryant			
19a. INFORMANT'S NAME (Type/Print) Marie C. Ritger (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7424 Old Battle Grove Road, Baltimore, Md. 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem 10/15		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cancer of peritoneum</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HBP</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>NA</u>		28b. TIME OF INJURY <u>NA</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D16347		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sheldon Amsel, Waxter Center, 861 Park Avenue, Baltimore, Md. 21201							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


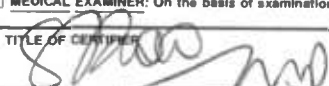

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30247

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRIEDA SMITH aka Frederica C. Smith		2. DATE OF DEATH MONTH DAY YEAR Oct. 7, 1994		3. TIME OF DEATH 8:50 p. M	
4. SOCIAL SECURITY NUMBER 212-01-4605		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.	
7. DATE OF BIRTH (Month, Day, Year) March 10, 1913		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Largo		9c. COUNTY OF DEATH Prince George	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 3417 Mayfield Avenue		10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/a College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Thomas Patrick Neary		18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Michael J. Boone (Nephew)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Old Largo Road, Upper Marlboro, Md. 20772			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 10/12		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. END STAGE CARCINOMA OF KIDNEY DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. METASTASIS to Lungs; DUE TO (OR AS A CONSEQUENCE OF):			
		c. pneumal effusion; DUE TO (OR AS A CONSEQUENCE OF):			
		d. Recurrent UTI			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus; she was "DNR" - "NOGR"					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) October 10, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.S Rao MD 4000 Mitchellville Road #214 Bowie, Maryland - 20716					
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30248

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSCOE EUGENE SMITH Sr.				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 9:00 A M	
4. SOCIAL SECURITY NUMBER 230-50-1925		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 22, 1938	
8. BIRTHPLACE (State or Foreign Country) Virginia				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 230 Orville Road				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		15b. KIND OF BUSINESS/INDUSTRY John Hopkins Hospital			
17. FATHER'S NAME (First, Middle, Last) Lester Smith				16. MOTHER'S NAME (First, Middle, Maiden Surname) Meda Jane Huffman			
19a. INFORMANT'S NAME (Type/Print) Dorothy Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Orville Road Baltimore MD. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10/14/94		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connolly</i>				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md/ 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>PANCREATIC CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 6 mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>HOSPICE</u>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>		29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD, TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) OCT 14 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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94 30249

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Joseph N. Schaefer, Sr.</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>12</u> YEAR <u>94</u>		3. TIME OF DEATH <u>1855</u> M	
4. SOCIAL SECURITY NUMBER <u>212-03-5642</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>95</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8-7-1899</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Centre</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>MD</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Anne Arundel</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore (Brooklyn Park)</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>5708 Magie Street</u>				10f. ZIP CODE <u>21225</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (14 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Supervisor</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Western Union</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Joseph Henry Schaefer</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Grace Anna McClarey</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mr. Donald Schaefer</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5709 Moore Street, Baltimore, Maryland 21225</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery 10/15/94</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kevin E. Ecker</u>				22. NAME AND ADDRESS OF FACILITY <u>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Infarction of R occipital lobe</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
<u>Intractable CHF</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ischemic Heart Disease</u> <u>Atrial Fibrillation</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. Shahriar T. Tabasi</u>				29c. LICENSE NUMBER <u>H.O. HHC</u>		29d. DATE SIGNED (Month, Day, Year) <u>10.12.94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dr. Shahriar Tabasi Harbor Hospital H.O., HHC Baltimore, MD</u>							
31. DATE FILED (Month, Day, Year) <u>10.12.94</u>				32. REGISTRAR'S SIGNATURE <u>John Senior Rude</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

המחלקה
15.11.4

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD L SMULLEN				2. DATE OF DEATH 10 MONTH 10 DAY 94 YEAR		3. TIME OF DEATH 8:40 PM	
4. SOCIAL SECURITY NUMBER 215-28-2229		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 23, 1931	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8343 Woodland Road	
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ---				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Social Security Administration	
17. FATHER'S NAME (First, Middle, Last) Andrew Smullen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Messick			
19a. INFORMANT'S NAME (Type/Print) Mrs. Florence T. Smullen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8343 Woodland Rd. Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 10/14/94 Glen Burnie, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John L. Polynick</i>				22. NAME AND ADDRESS OF FACILITY Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Exsanguination</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Abdominal aortic aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic heart disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur L. Gudwin</i>				29c. LICENSE NUMBER D08609		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARTHUR L. GUDWIN, M.D./EMPIRE TOWER, #500 7310 RITCHIE HWY/GLEN BURNIE, MARYLAND							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Maryland Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30251

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Bettie Stabler</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>10</i> YEAR <i>94</i>		3. TIME OF DEATH <i>9:40 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216 46 8695</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/31/06</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Longview Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Manchester</i>		9c. COUNTY OF DEATH <i>Carroll</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Manchester</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3332 Main St.</i>				10f. ZIP CODE <i>21102</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>H.S.</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Librarian</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Library</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Henry J. Stabler</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bettie Taylor Reid</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Springfield Hospital Records</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Sykesville, Md. 21784</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Springfield Cemetery 10/18/94</i>		20c. LOCATION — City or Town, State <i>Sykesville, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Haight</i>				22. NAME AND ADDRESS OF FACILITY <i>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bronchopneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Organic Brain Syndrome - Schizophrenia - Paranoid Thalassemia Minor</i>							Approximate Interval Between Onset and Death <i>3 days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Organic Brain Syndrome - Schizophrenia - Paranoid Thalassemia Minor</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <i>M</i>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>W H Hoard MD</i>			
29c. LICENSE NUMBER <i>D02386</i>				29d. DATE SIGNED (Month, Day, Year) <i>10/10/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>W. H. Hoard MD 3223 Main St, Manchester, Md 21102</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 14 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Anderson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jesse Emerson Taylor				2. DATE OF DEATH MONTH DAY YEAR October 12 1994		3. TIME OF DEATH 1:25 p.m.	
4. SOCIAL SECURITY NUMBER 711-07-6369		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1918	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not institution, give street and number) 1502 Aldeney Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 1502 Aldeney Avenue				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tugboat Operator		16b. KIND OF BUSINESS/INDUSTRY Maryland Shipbuilding and Drydock			
17. FATHER'S NAME (First, Middle, Last) William Henry Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Capel			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary L. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Aldeney Avenue Baltimore, Md. 21220			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 10/14/94		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Transitional Cell Carcinoma of Urinary Bladder 1 year Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL 1 Inpatient 2 Outpatient 3 Outpatient 4 Nursing Home 5 Residence 6 Other (Specify)		27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER ROBERT F. HOOFNAGLE MD				29c. LICENSE NUMBER D35873		29d. DATE SIGNED (Month, Day, Year) 10-13-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.F. HOOFNAGLE MD 9101 Franklin Square DRIVE BALTIMORE MD 21237							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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94 30253

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS WILLIAM TRACEY				2. DATE OF DEATH MONTH OCT DAY 10 YEAR 94		3. TIME OF DEATH A <input checked="" type="checkbox"/> M <input type="checkbox"/>	
4. SOCIAL SECURITY NUMBER 216-32-3264		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC 28 1934	
8a. FACILITY NAME (If not institution, give street and number) 8009 BELLE HAVEN AVENUE				8b. CITY, TOWN OR LOCATION OF DEATH PASADENA		8c. COUNTY OF DEATH ANNE ARUNDEL	
9. RESIDENCE OF DECEDENT				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION PASADENA				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 8009 BELLE HAVEN AVENUE				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONGSHOREMAN		16b. KIND OF BUSINESS/INDUSTRY SHIPPING			
17. FATHER'S NAME (First, Middle, Last) FRANKLIN G. TRACEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY B SMITH			
19a. INFORMANT'S NAME (Type/Print) MRS. BARBARA TRACEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 BELLE HAVEN AVE, PASADENA, MD 21122			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Mem Park 10/13		20c. LOCATION — City or Town, State Glen Burnie, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven H. Williams				22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Road, Pasadena, MD 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Mixed Small Cell/Non-small Carcinoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. De Long with pleural, Adrenal c. cutting of Neck Relebase d. Due to (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 3 mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Russell R. Pollock				29c. LICENSE NUMBER 032557		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Russell R. Pollock, MD 1600 Crain Highway, Suite 410, Glen Burnie, Md. 21061							
31. DATE FILED (Month, Day, Year) OCT 14 1994		32. REGISTRAR'S SIGNATURE John B. Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30254

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Maurice C. Tillery				2. DATE OF DEATH MONTH DAY YEAR Oct. 12, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 215-09-9369		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7/3/1912	
9a. FACILITY NAME (If not institution, give street and number) 518 E. Fort Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.		9c. COUNTY OF DEATH -----	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY A.A. Co.		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 412 Carvel Beach Rd.				10f. ZIP CODE 21226		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Martin Marietta			
17. FATHER'S NAME (First, Middle, Last) John Thomas Tillery				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie E. Kraft			
19a. INFORMANT'S NAME (Type/Print) Madeline A. Tansill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 E. Fort Ave. Balto. Md. 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Cedar Hill Cemt. 10/15/94		20c. LOCATION — City or Town, State A.A. Co. Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Daniel A. Taylor				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. acute Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): b. renal failure DUE TO (OR AS A CONSEQUENCE OF): c. on Hemodialysis DUE TO (OR AS A CONSEQUENCE OF): d. old Myocardial Infarction							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D14136		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DALIT S. SAWHNEY Suite 201 Crain Towers 1600 Crain Hwy Glen Burnie Md 21061							
31. DATE FILED (Month, Day, Year) 10/13/1994		32. REGISTRAR'S SIGNATURE J. J. [Signature] OCT 14 1994					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 25 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30255

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Herman Daniel Wistland, Sr.				2. DATE OF DEATH MONTH DAY YEAR October 10, 1994		3. TIME OF DEATH 7:20 A. M	
4. SOCIAL SECURITY NUMBER 213-07-8997		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1911	
9a. FACILITY NAME (If not institution, give street and number) Ivy Hall Geriatric Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Perry Hall		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4600 Silver Spring Road				10f. ZIP CODE 21128		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Steel Company			
17. FATHER'S NAME (First, Middle, Last) Henry Wistland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Sapp			
19a. INFORMANT'S NAME (Type/Print) Thelma A. Wistland (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Silver Spring Rd., Perry Hall, MD 21128			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem.		DATE 10/13		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene J. L...</i>				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Possible Aortic MI</i> Due to (OR AS A CONSEQUENCE OF): b. <i>Demerol</i> Due to (OR AS A CONSEQUENCE OF): c. <i>Old CVA</i> Due to (OR AS A CONSEQUENCE OF): d. <i>C</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Tarique A. Firozvi</i>				29c. LICENSE NUMBER D14221		29d. DATE SIGNED (Month, Day, Year) 10.12.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Tarique A. Firozvi, 223 Eastern Blvd., Baltimore, MD 21221							
31. DATE FILED (Month, Day, Year) 10/14/94				REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30256

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dennis Williamson				2. DATE OF DEATH MONTH DAY YEAR 10 13 94		3. TIME OF DEATH 550A M		
4. SOCIAL SECURITY NUMBER 216-24-5796		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-11-27		
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) 1213 Light St		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		
9c. COUNTY OF DEATH				10a. STATE Md.				
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore				
10d. INSIDE CITY LIMITS? 1 X YES 2 NO				10e. STREET AND NUMBER 1213 Light St				
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO		14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vehicle Operator		16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) Roman Williamson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Wells				
19a. INFORMANT'S NAME (Type/Print) Edith Eleanor Gordon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1228 Holloway Rd - DARTINGTON MD. 21034				
20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		20c. LOCATION — City or Town, State Baltimore Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY WM.C. BROWN COMMUNITY F/H 1206 W. NORTH AVE				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung cancer with metastasis DUE TO (OR AS A CONSEQUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CVA with Right Hemiplegic DUE TO (OR AS A CONSEQUENCE OF):								
DIM DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 X Nursing Home 5 Residence 6 Other (Specify)						
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER A. Khokhlov MD				29c. LICENSE NUMBER D32700		29d. DATE SIGNED (Month, Day, Year) 10/13/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE [Signature]				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it can be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30257

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN MILDRED WEBB				2. DATE OF DEATH MONTH 10 DAY 7 YEAR 94		3. TIME OF DEATH 1610 M	
4. SOCIAL SECURITY NUMBER 215-12-1123		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/29/22	
8. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9. CITY, TOWN OR LOCATION OF DEATH Baltimore		10. COUNTY OF DEATH MD	
11. RESIDENCE OF DECEDENT				12. CITY, TOWN OR LOCATION BALTIMORE		13. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
14. STATE MD.		15. COUNTY		16. CITY, TOWN OR LOCATION BALTIMORE		17. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
18. STREET AND NUMBER 2505 BANGER ST.				19. ZIP CODE 21230		20. CITIZEN OF WHAT COUNTRY? USA	
21. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: WHITE	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Packer		27. KIND OF BUSINESS/INDUSTRY Factory			
28. FATHER'S NAME (First, Middle, Last) Benjamin F. Thompson				29. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet Higdon			
30. INFORMANT'S NAME (Type/Print) Mrs. Christine Kraft				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Banger Street Baltimore, MD 21230			
32. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 10/11		34. LOCATION — City or Town, State Balt. MD			
35. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven H. Williams				36. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Avenue, Baltimore, 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER FAILURE							
DUE TO (OR AS A CONSEQUENCE OF): RENAL FAILURE							
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST. METASTATIC CARCINOMATOSIS							
DUE TO (OR AS A CONSEQUENCE OF): CECAL CARCINOMA							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, HYPERTENSION							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER S. Hasan MD				29c. LICENSE NUMBER 1883		29d. DATE SIGNED (Month, Day, Year) 10/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. S. Hasan, St Agnes Hosp, 900 Caton Ave, Baltimore							
31. DATE FILED (Month, Day, Year) 10/7/94 OCT 14 1994				32. REGISTRAR'S SIGNATURE John Benison-Rudolph			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

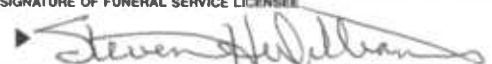

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30258

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY A. ZEMAN				2. DATE OF DEATH MONTH 10 DAY 7 YEAR 94		3. TIME OF DEATH 21:50 M	
4. SOCIAL SECURITY NUMBER 358-24-6527		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-4-04	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nurs, Home Spa Creek				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis, Md.		9c. COUNTY OF DEATH A.A.Co.	
10a. STATE Maryland				10b. COUNTY A.A.Co.		10c. CITY, TOWN OR LOCATION Edgewater, Md.	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 137 Edgewood Dr.			
10f. ZIP CODE 20137				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 6th. Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Vincent --- Kuchar				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna --- Malecek			
19a. INFORMANT'S NAME (Type/Print) Mr, Charles Zeman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Edgewood Dr. Edgewater, Md. 20137			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bohemian Cemt. Nat. 10/11/94		20c. LOCATION — City or Town, State Berwyn, Ill.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Large left hemispheric Stroke & Rt. Hemiplegia DUE TO (OR AS A CONSEQUENCE OF) Cerebral embolus DUE TO (OR AS A CONSEQUENCE OF) Atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF) Revised M.D. Deputy M.D. A.A. Co. 10/11/94 Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia; Rt. hip fracture							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-31-94		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Fell out of bed				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Pleasant Living N. Ctr Edgewater MD 21037			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Peter F. Verkouwen				29c. LICENSE NUMBER 011653		29d. DATE SIGNED (Month, Day, Year) 10-8-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter F. VERKOUW, MD, 1833 Forest Dr., Annapolis, MD, 21401							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30259

Item20c 1-20-95 FilmG719 W.H.Per Cemetery/F/H

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH A. ZICK JR.				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 12:05 A.M.	
4. SOCIAL SECURITY NUMBER 219-56-8253		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 09-06-50	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA	
9c. COUNTY OF DEATH HOWARD				10a. STATE MARYLAND			
10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION COLUMBIA		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 9708 POLISHED STONE				10f. ZIP CODE 21046		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSOCIATE BROKER		16b. KIND OF BUSINESS/INDUSTRY REAL ESTATE			
17. FATHER'S NAME (First, Middle, Last) JOSEPH A. ZICK SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS NICHOLS			
19a. INFORMANT'S NAME (Type/Print) MARY TAYLOR ZICK (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9708 POLISHED STONE COLUMBIA MARYLAND 21046			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHRIST EPISCOPAL CHURCH CEMETERY BALTIMORE, MARYLAND		20c. LOCATION — City or Town, State Columbia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. Coronary heart disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 hrs. 1990 1979							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER D13998		29d. DATE SIGNED (Month/Day/Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alan G. Stahl, M.D. 4801 Dorsey Hall Dr. E.C. 2104							
31. DATE FILED (Month, Day, Year) OCT 14 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GENEVA AVERY				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 9:41 PM	
4. SOCIAL SECURITY NUMBER 214-18-9541		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUL 30, 1913	
8. BIRTHPLACE (State or Foreign Country) N. CAROLINA		9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1935 RAMBLEWOOD ROAD				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY LAUNDRY INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) JEFFERSON ALEXANDER Jeffery Alexander				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE BROWN			
19a. INFORMANT'S NAME (Type/Print) CORNELIUS AVERY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1231 BEAUMONT AVENUE, BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 10+15		20c. LOCATION — City or Town, State LANSDOWNE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See Holland</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCHFH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) n.a.		28b. TIME OF INJURY n.a. M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED n.a.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) n.a.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) n.a.	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 106715		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ALVIN SANICO GOOD SAMARITAN HOSPITAL 5601 LOCHRAVEN BLVD BALTIMORE							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

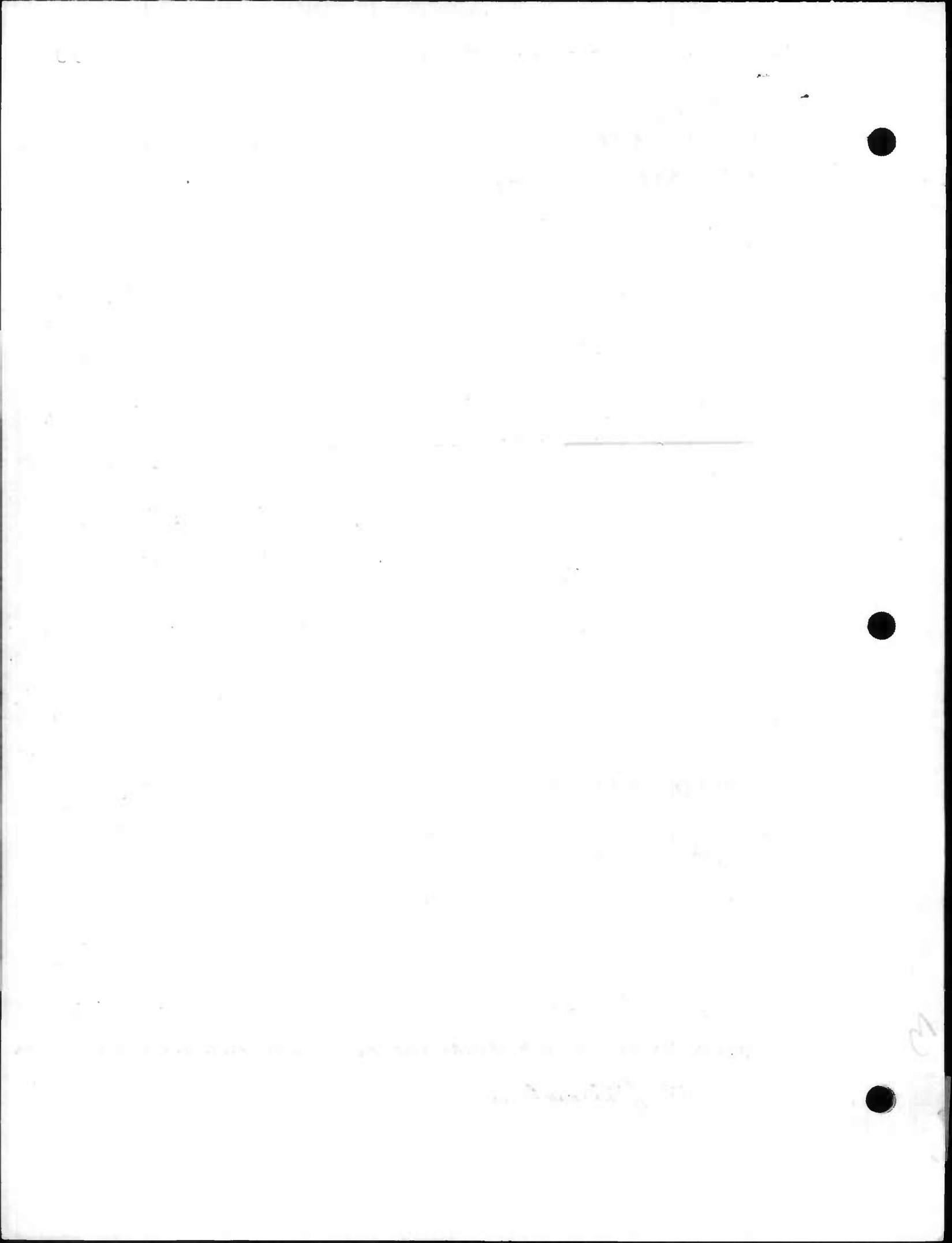
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30262

Item#20b Per F.H. Item# G-716 10/21/94 R.M.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMMA E. BREIT				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 5A M	
4. SOCIAL SECURITY NUMBER 220-42-9001		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 10, 1926	
8. BIRTHPLACE (State or Foreign Country) Germany				9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
9c. COUNTY OF DEATH Baltimore County				10a. STATE Maryland		10b. COUNTY Baltimore Co.	
10c. CITY, TOWN OR LOCATION Reisterstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 714 Berrymans Lane	
10f. ZIP CODE 21136				10g. CITIZEN OF WHAT COUNTRY? Germany		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Homemaker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY ---	
17. FATHER'S NAME (First, Middle, Last) August Hahn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Tatsh			
19a. INFORMANT'S NAME (Type/Print) Mr. Franz Breit				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Berrymans Lane Reisterstown, MD 21136			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 10-19		20c. LOCATION — City or Town, State Sykesville, MD 10-20	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayndt				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PERIPHERAL VASCULAR DISEASE c. DIABETES MELLITUS TYPE II							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. [Signature] MD				29c. LICENSE NUMBER D27157		29d. DATE SIGNED (Month, Day, Year) 10-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked "N/A" or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[REDACTED]



94 30263

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Pearl Binkley				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 10:00 p.m.	
4. SOCIAL SECURITY NUMBER 277-07-0352		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/29/1898	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Baltimore			
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home-PerringPk				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY ----		10c. CITY, TOWN OR LOCATION Parkville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2811 Bauernwood Avenue				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Jacob Stein				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Brandt			
19a. INFORMANT'S NAME (Type/Print) Pauline G. Treptow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Bauernwood Avenue Parkville, MD 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Netro Crematory, Inc.		DATE 10/17		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ISCHEMIC CARDIOMYOPATHY. b. DUE TO (OR AS A CONSEQUENCE OF): ARTERIO-SCLEROTIC HEART DISEASE. c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D-10397		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ruben Sebastian, M.D. 2314 East Joppa Rd. Towson, MD 21234							
31. DATE FILED (Month, Day, Year) OCT 17 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5837-510

94-189

94 30264

blh

Item#1.G-film716 per F.H 10/21/94 P.C

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Donte^s Antwan Burnett</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Oct. 10 1994</u>		3. TIME OF DEATH <u>2246</u> M	
4. SOCIAL SECURITY NUMBER <u>216-86-2472</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>18</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>JUN. 15, 1976</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Dunbar Athletic Field- 1200 blk E Monument Street</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>n/a</u>	
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3129 LAWNVIEW AVENUE</u>				10f. ZIP CODE <u>21213</u>		10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9 TH</u> College (1-4 or 5+) <u>-</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>LABORER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>n/a</u>			
17. FATHER'S NAME (First, Middle, Last) <u>BOBBY BURNETT</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>JEWELL HARRIS</u>			
19a. INFORMANT'S NAME (Type/Print) <u>BOBBY BURNETT</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3129 LAWNVIEW AVENUE, BALTIMORE, MARYLAND #13</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>VOSHALL MEMORIAL GARDENS</u>		DATE <u>10-17</u>		20c. LOCATION — City or Town, State <u>DUNDALK, MARYLAND</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Juan Chapman</u>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Multiple Gunshot Wounds</u> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>at scene</u>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>10/10/94</u>		28b. TIME OF INJURY <u>2235</u> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u>Subject shot</u>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>STREET</u>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>1200 E. BLK. Monument St.</u>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>David Liche MD</u>				29c. LICENSE NUMBER <u>O.C.M.E.</u>		29d. DATE SIGNED (Month, Day, Year) <u>Oct. 11 1994</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John W. Loker MD</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>		32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL

The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30265

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OWEEIDA GAIL BAPTIST				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 8, 1994		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 820-06-3514		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 29, 1916	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6401 LOCH RAVEN BOULEVARD	
10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) CHARLES ROBINSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGIE			
19a. INFORMANT'S NAME (Type/Print) LATANYA GREEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1557 SHERWOOD AVE./BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 10-13		20c. LOCATION — City or Town, State RANDALLSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVE./BALTIMORE, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis secondary to Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Healing fracture of left hip						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 9-3-94		28b. TIME OF INJURY A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Fell on Hall		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Retirement Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6700 Bal Harbour Blvd			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-09383		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Charles F. O'Donnell MD - 508 Harper House - 111 Hamlet Hill Rd							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30266

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Margaret Lillian Burroughs</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Oct. 14 1994</u>		3. TIME OF DEATH <u>@:2:20PM</u>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>61</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>Dec. 23, 1932</u>		8. BIRTHPLACE (State or Foreign Country) <u>S.C.</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Prince Georges General Hospital Cheverly</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>P.G.</u>		9c. COUNTY OF DEATH <u>P.G.</u>	
10a. STATE <u>MD</u>		10b. COUNTY <u>P.G.</u>		10c. CITY, TOWN OR LOCATION <u>Capitol Heights</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>7004 Canyon Dr</u>				10f. ZIP CODE <u>20743</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <u>X</u>		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>Henry Tidwell</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>William Burroughs</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7004 Canyon Dr. Cap. Hqts. Md. 20743</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Maryland Nat. Cem Oct. 20, 1994 Laurel, Md.</u>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Prince Edwards</u>				22. NAME AND ADDRESS OF FACILITY <u>Hodges and Edwards</u> <u>3910 Silver Hill Rd. Suit. Land, Md.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Anoxic Encephalopathy</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <u>Ischemic Heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <u>Hypertensive Cardiovascular Disease</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>H.A. Molauai MD</u>				29c. LICENSE NUMBER <u>D12863</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/14/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>H.A. Molauai, MD. 6005 Landover Rd. Cheverly, Md. 20785</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>		32. REGISTRAR'S SIGNATURE <u>John S. Borden</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


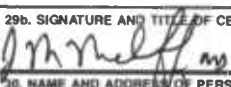
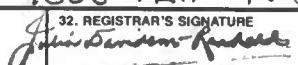
TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30267

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET		Margaret Mary Bowen		2. DATE OF DEATH MONTH 10 DAY 13 YEAR 94		3. TIME OF DEATH 11:00 P.M.	
4. SOCIAL SECURITY NUMBER 217-20-4429		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/14/26	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) Franklin Woods Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11226 Loreley Beach Road				10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Electrical Co.			
17. FATHER'S NAME (First, Middle, Last) John Hammelman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Zipfel			
19a. INFORMANT'S NAME (Type/Print) Loretta O'Bradovich				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7724 Laytonia Dr. Gaithersburg, Md. 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 10-17-94		20c. LOCATION — City or Town, State Overlea, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md.			
23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29197		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. M. NIEHOFF, MD 9000 FRANKLIN SQUARE DR. BALTIMORE, MD. 21237							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30268

Item # 6 Film # G 716 10-17-94 N.A. Per funeral Home Item # 1 Per funeral Home

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHARON BENTON (TOMS)				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 12 1994				3. TIME OF DEATH 12:49 P M	
4. SOCIAL SECURITY NUMBER 220-64 0231		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/2/56		8. BIRTHPLACE (State or Foreign Country) Md	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Balt				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2878 Harford Rd				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Health Care			16b. KIND OF BUSINESS/INDUSTRY STATE 8 Md		
17. FATHER'S NAME (First, Middle, Last) RALPH TOMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED HILL					
19a. INFORMANT'S NAME (Type/Print) Mildred Toms				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1840 E. 28th St Baltimore Md 21218					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore cem 10/18 North Ave + Port St		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locks				22. NAME AND ADDRESS OF FACILITY Locks Funeral Home 1304 N. Central Ave					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. BILATERAL PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. HUMAN IMMUNODEFICIENCY VIRUS DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death 6 DAYS 6 DAYS 7-2 YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, LIVER FAILURE								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Carol Smith MD					
29c. LICENSE NUMBER L4718				29d. DATE SIGNED (Month, Day, Year) 10/12/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St 110 TOWER BALTIMORE MARYLAND 21287									
31. DATE FILED (Month, Day, Year) OCT 11 1994				32. REGISTRAR'S SIGNATURE John Sanders Registrar					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5834-510


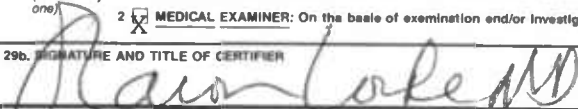
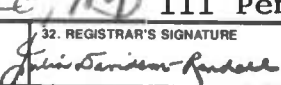
L.R.B.

94 30269

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-716 10/28/94 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PHILLIP LESTER BUTTS JR.			2. DATE OF DEATH MONTH DAY YEAR OCT 10 1994		3. TIME OF DEATH M 5:15P
4. SOCIAL SECURITY NUMBER 219-84-9433	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 31 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-2-63		8. BIRTHPLACE (State or Foreign Country) Norfolk, Va.
9a. FACILITY NAME (If not institution, give street and number) 514 CATHEDRAL STREET.			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.		9c. COUNTY OF DEATH
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER 3861 Twin Lakes Ct.		
10f. ZIP CODE 21244		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Muscian		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last) Phillip Lester Butts Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Gilliam		
19a. INFORMANT'S NAME (Type/Print) Phillip L. Butts Sr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Highland Dr. Apt. T4 Glen Burnie, Md. 21060		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Annapolis Memorial 10-14		20c. LOCATION — City or Town, State Annapolis, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY William C. Brown Community F.H. 1206 W. North Ave. Balto. Md. 21217		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC, COCAINE & ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND 10-10-94		28b. TIME OF INJURY UNKNOWN	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MD.		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 11 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201.					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30270

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL A BRAUN-FOSTER				2. DATE OF DEATH MONTH DAY YEAR 10 09 94		3. TIME OF DEATH 02:40 PM	
4. SOCIAL SECURITY NUMBER 212-10-6186		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul. 12, 1915	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Severn				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7969 Foster Avenue	
10f. ZIP CODE 21144				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Household	
17. FATHER'S NAME (First, Middle, Last) George Ladner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Yingling			
19a. INFORMANT'S NAME (Type/Print) Bernard J. Foster Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7969 Foster Ave. Severn, MD 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, etc.) Meadowridge Memorial Park		20c. LOCATION — City or Town, State Dorsey, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patrol J. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Approximate Interval Between Onset and Death 5 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marc Okun</i>				29c. LICENSE NUMBER DZ8000		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARC OKUN, M.D. / 203 HOSPITAL DRIVE, #206/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>Julius [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30271

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hazel Rickards Bigler				2. DATE OF DEATH MONTH DAY YEAR Oct. 10, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 164-07-0887		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 23, 1911	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD			
10b. COUNTY Anne Arundel				10c. CITY, TOWN OR LOCATION Crofton			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2085 Pear Hill Court			
10f. ZIP CODE 21114				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Albert W. Rickards Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma C. Medlam			
19a. INFORMANT'S NAME (Type/Print) Robert J. Bigler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2085 Pear Hill Court, Crofton, MD 21114			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Cemetery		20c. LOCATION — City or Town, State Upper Darby, PA		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Bigler</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Resp Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Resp Failure b. CIR c. d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D36761		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) 2568 Nova Rd Annapolis MD 21401							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3.

4.

94 30272

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Frances Bowers</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>12</i> YEAR <i>04</i>		3. TIME OF DEATH <i>0025</i> M	
4. SOCIAL SECURITY NUMBER <i>215-09-9469</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8/15/08</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Merry Medical Center</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		8c. COUNTY OF DEATH <i>BALTIMORE CITY, MD.</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>600 LIGHT STREET</i>				10f. ZIP CODE <i>21230</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SEAMSTRESS</i>		16b. KIND OF BUSINESS/INDUSTRY <i>CLOTHING</i>			
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM F. MACNEAL</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SARAH E. LINTHICUM</i>			
19a. INFORMANT'S NAME (Type/Print) <i>WILLIAM C. BOWERS</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>340 ELINOR AVE. BALTIMORE, MD. 21236</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GARDENS OF FAITH CEM. 10/15/94</i>		DATE <i>10/15/94</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MD/</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Lassahn Funeral Home 7401 Belair Rd. Balt., MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. metastatic cancer</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Journa Chon MD</i>				29c. LICENSE NUMBER <i>A44176435AC2731</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/12/04</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Journa Chon 17 S. Greene St. Balt MD 21201</i>							
31. DATE OF DEATH (Month, Day, Year) <i>OCT 11 1994</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30273

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAWRENCE F. BRUDER JR.				2. DATE OF DEATH MONTH DAY YEAR October 14, 1994		3. TIME OF DEATH 6:40 A M	
4. SOCIAL SECURITY NUMBER 213-26-7654		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1930	
8a. FACILITY NAME (If not institution, give street and number) 6911 Beech Avenue				8b. CITY, TOWN OR LOCATION OF DEATH Overlea		8c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Overlea		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6911 Beech Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrical Engineer		16b. KIND OF BUSINESS/INDUSTRY Enviromental Elements Corp.			
17. FATHER'S NAME (First, Middle, Last) Lawrence Frederick Bruder, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Mae Gurney			
19a. INFORMANT'S NAME (Type/Print) Mrs. Carolyn S. Bruder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6911 Beech Avenue Baltimore, Md. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery 10/17/94 Balto., Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non Small Cell Lung DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur A. Serpick</i>				29c. LICENSE NUMBER D 10091		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur A. Serpick, M. D. 7620 York Rd. Towson, Md. 21204 (337-1205)							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Augusta Brooks				2. DATE OF DEATH MONTH DAY YEAR Oct 7 1994		3. TIME OF DEATH 9:30 a m							
4. SOCIAL SECURITY NUMBER 217-05-2507		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov-20-1904		8. BIRTHPLACE (State or Foreign Country) Virginia					
9a. FACILITY NAME (If not institution, give street and number) 3500 N. Ellamont Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 3500 N. Ellamont Rd.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HouseWife		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Thornton Wilson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth									
19a. INFORMANT'S NAME (Type/Print) Lillian Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 N. Ellamont Rd./ Balt. MD. 21215									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK		DATE 10/13		20c. LOCATION — City or Town, State BALTO. MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Follin</i>				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Home Inc. 2501 Gwynn Falls Pky Baltimore, Maryland 21216									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASEVD.</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Hypertension</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Somiting</i>								Approximate Interval Between Onset and Death <i>4 hrs.</i> <i>4 hrs.</i>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>D.P. Malayan</i>		29c. LICENSE NUMBER D18396		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.P. Malayan, M.D. 4001 Wilkens Ave Balto 21229.													
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30275

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Elaine, NMI Carroll</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>10</u> YEAR <u>94</u>		3. TIME OF DEATH <u>8:55 P M</u>	
4. SOCIAL SECURITY NUMBER <u>214-44-8463</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>48</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10-17-1945</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Ba Ht</u>		9c. COUNTY OF DEATH <u>md</u>	
10a. STATE <u>md</u>				10b. COUNTY <u>Ba Ht</u>		10c. CITY, TOWN OR LOCATION <u>Ba Ht</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>574 N. Monroe St</u>		10f. ZIP CODE <u>21223</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11th</u> College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>unknown</u>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>Frances Stewart</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alice Henderson</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Beverly Henderson</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>636 Mosher St Ba Ht, Md 21217</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home or other place) <u>King Men Park 10/17/94</u>		20c. LOCATION — City or Town, State <u>Randallstown, md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Portia Ebron</u>				22. NAME AND ADDRESS OF FACILITY <u>Maugh F. H. West 7300 Wabash Ave Baltimore 21215</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Large Intracerebral Hematoma</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>4d.</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Insulin Dependent Diabetes Mellitus</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Tha no.</u>				29c. LICENSE NUMBER <u>7474</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/11/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>GAUTAM THAKUR, NEUROSURGERY 125 HALL D.</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Russell</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30276

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Howard D. Cassidy</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>11</i> YEAR <i>94</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>201-30-5520</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>54</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-23-40</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>1815 Oriole Court</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Severn</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Severn</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1815 Oriole Court</i>				10f. ZIP CODE <i>21144</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <i>Military</i>	
17. FATHER'S NAME (First, Middle, Last) <i>James Cassidy</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Marie Drake</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Barbara J. Cassidy</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1815 Oriole Court Severn, MD 21144</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington Nat Cem</i>		20c. DATE <i>10/18/94</i>		20d. LOCATION — City or Town, State <i>Arlington, Va</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Ebron</i>				22. NAME AND ADDRESS OF FACILITY <i>Manly F. H. West 4300 Wabash Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. metastatic nonsmall cell lung cancer</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arnon W. Berkman MD</i>				29c. LICENSE NUMBER <i>022782</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/18/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Arnon W. Berkman MD Harbor Hospital Center</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>		32. REGISTRAR'S SIGNATURE <i>John S. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30277

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elmer P. Curtin				2. DATE OF DEATH MONTH DAY YEAR October 12 1994		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 215-38-7718		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 3, 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Anne Arundel			
9a. FACILITY NAME (If not institution, give street and number) 1178 Claire Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Crownsville		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Md.				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Crownsville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1178 Claire Rd.				10f. ZIP CODE 21032		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Military		16b. KIND OF BUSINESS/INDUSTRY U. S. Army	
17. FATHER'S NAME (First, Middle, Last) Alston Curtin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Hidden			
19a. INFORMANT'S NAME (Type/Print) Craig C. Curtin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Simms Landing Rd., Crownsville, Md. 21032			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville Veterans Cem. 10/14		20c. LOCATION — City or Town, State Crownsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>infected decubitus ulcer</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>bedridden due to cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 3 months 7 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Leandro G. Peña, MD</i> CPT MC 463-29-8721				29c. LICENSE NUMBER TX-J0186		29d. DATE SIGNED (Month, Day, Year) 13 Oct 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print) Kimbrough Army Hospital FGGM MD 20755.							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John Sander-Kinder</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Internal Medicine
403 - 58 - 8751
CPT MC
J. Pedro C. Peña, MD

94 30278

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES COUSER				2. DATE OF DEATH OCTOBER 12, 1994		3. TIME OF DEATH 8:16A	
4. SOCIAL SECURITY NUMBER 249-26-9826		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH 3/18/1910		8. BIRTHPLACE (State or Foreign Country) S. Carolina	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 1134 Homewood Avenue				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian		16b. KIND OF BUSINESS/INDUSTRY Auto Service Station			
17. FATHER'S NAME (First, Middle, Last) WILLIE COUSER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MATILDA COKER			
19a. INFORMANT'S NAME (Type/Print) Leon Couser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7007 N. Alter Street Baltimore, MD 21207			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 10/17		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary aspiration Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 2 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary secretions, renal failure							
24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Weiner MD</i> MEDICAL RESIDENT				29c. LICENSE NUMBER M0277		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Weiner, JHH, Tower 110, 600 N. Wolfe St, Baltimore MD 21287							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>Julia A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30279

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alfonso Clark				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 7:00 A	
4. SOCIAL SECURITY NUMBER 713-64-5311		5. SEX M <input type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/26/55	
8. BIRTHPLACE (State or Foreign Country) N.Y.C.				9a. FACILITY NAME (If not institution, give street and number) BON SECORS Hosp		9b. CITY, TOWN OR LOCATION OF DEATH Balto. Md	
9c. COUNTY OF DEATH				10a. STATE MD			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Balto			
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 824 ALLENDALE Rd			
10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Herbert CLARK				18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL MAY WATSON			
19a. INFORMANT'S NAME (Type/Print) Herbert Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Alendale Rd, Balto. Md, 21228			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wentworth mem PK 10/11/94		20c. LOCATION — City or Town, State Baltimore Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locke Jr	
22. NAME AND ADDRESS OF FACILITY Locke Funeral Home 1304 N. Central St		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → status post Cardio pulmonary arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Cerebral Anoxia b. ventricular fibrillation / asystole c. gondroplegia and to Cervical spine injury d. 1972					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)						27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Carolina D. Alvarado physician				29c. LICENSE NUMBER D29769		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carolina D. Alvarado 5600 Rolling Rd Balto							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John S. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30280

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARL P CIRUL				2. DATE OF DEATH MONTH DAY YEAR 10 16 94		3. TIME OF DEATH 08:30 AM	
4. SOCIAL SECURITY NUMBER 218 03 6591		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/16/1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Riviera Beach				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 228 Arundel Road	
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years College (1-4 or 5+) 2 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marine Engineer		16b. KIND OF BUSINESS/INDUSTRY Maritime	
17. FATHER'S NAME (First, Middle, Last) Carl R. Cirul				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances			
19a. INFORMANT'S NAME (Type/Print) Ellen Cirul				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Arundel Road Riviera Beach, Maryland 21122			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 10/19 Baltimore, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart Failure DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 Days Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Alzheimer's Disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin J. Doyle</i>				29c. LICENSE NUMBER D31122		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. DOYLE, M.D./203 HOSPITAL DRIVE, #206/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Danden-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30281

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUKE PHILIP COUNIHAN				2. DATE OF DEATH MONTH DAY YEAR OCT. 7, 1994		3. TIME OF DEATH M 7:25 PM	
4. SOCIAL SECURITY NUMBER N/A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 2		7. DATE OF BIRTH (Month, Day, Year) Oct. 7, 1994	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery Co.	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery Co.		10c. CITY, TOWN OR LOCATION Laytonsville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 21835 Glendalough Road				10f. ZIP CODE 20882		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) James Patrick Counihan, III				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lorraine Pierce			
19a. INFORMANT'S NAME (Type/Print) James Patrick Counihan, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21835 Glendalough Rd, Laytonsville, MD 20882			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Northern VA Crematory 10/12		20c. LOCATION — City or Town, State Arlington, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay A. Keston</i>				22. NAME AND ADDRESS OF FACILITY Murphy Falls Church Funeral Home, 1102 W. Broad St, Falls / Church, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. PULMONARY HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 2 hrs	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. MULTIPLE CONGENITAL ANOMALIES DUE TO (OR AS A CONSEQUENCE OF):				2 hrs	
		c. PENTAGON OF CONTROL DUE TO (OR AS A CONSEQUENCE OF):				2 hrs	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stavros P. Warner</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STAVROS P. WARNER, MD Holy Cross Hosp, 1500 Forest Glen Rd, Silver Spring, MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994		REGISTRAR'S SIGNATURE <i>J. H. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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94 30282

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RACHEL CRANE				2. DATE OF DEATH MONTH 10 DAY 05 YEAR 94				3. TIME OF DEATH 12:00 Noon	
4. SOCIAL SECURITY NUMBER 312-03-5945		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) July 27, 1905	
8. BIRTHPLACE (State or Foreign Country) Niles, Michigan				9a. FACILITY NAME (If not institution, give street and number) Hebrew Home Of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE D.C.				10b. COUNTY None	
10c. CITY, TOWN OR LOCATION Washington				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 730 24th Street, Apt. 420	
10f. ZIP CODE 20037				10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES _____				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Abraham Samuel Krinowitz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Moskowicz				19a. INFORMANT'S NAME (Type/Print) Murray R. Welsh	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24121 Ridge Road, Germantown, Maryland 20876				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Garden 10/10/1994	
20c. LOCATION — City or Town, State Falls Church, Virginia				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stettin				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ b. _____ c. _____ d. _____									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) _____		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED _____				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Stacy Physician				29c. LICENSE NUMBER D18084				29d. DATE SIGNED (Month, Day, Year) 10/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852									
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Davidson					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30283

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM H. DAVIS SR.				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 3:15 P	
4. SOCIAL SECURITY NUMBER 366-16-2245		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	7. DATE OF BIRTH (Month, Day, Year) 09 09 08		8. BIRTHPLACE (State or Foreign Country) NEW YORK	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SEVERNA PARK		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 770 221ST STREET		10f. ZIP CODE 21122	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED BUILDER		17. KIND OF BUSINESS/INDUSTRY CONSTRUCTION	
18. FATHER'S NAME (First, Middle, Last) WILL DAVIS				19. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA STROMGREN			
20. INFORMANT'S NAME (Type/Print) PHEBE M. DAVIS				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 770 221ST STREET-PASADENA, MD. 21122			
22. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 10/17		24. LOCATION — City or Town, State CATONSVILLE, MD.	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				26. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE b. PNEUMONIA c. DEMENTIA d. RESPIRATORY FAILURE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA							
29. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A			
31. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				32. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				34. DATE OF INJURY (Month, Day, Year)		35. TIME OF INJURY M	
36. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				37. DESCRIBE HOW INJURY OCCURRED			
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				39. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
40. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
41. SIGNATURE AND TITLE OF CERTIFIER <i>Stallard Attending</i>				42. LICENSE NUMBER D 21776		43. DATE SIGNED (Month, Day, Year) 10/12/94.	
44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURYA P. MUNDRA M.D. 203 E. PATAPSCO AVENUE-BALTIMORE, MD. 21225							
45. DATE FILED (Month, Day, Year) 001171994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or name, located in the center of the page.

Vertical handwritten text, possibly a list or series of notes, located on the right side of the page.

Handwritten text at the bottom left, possibly a date or reference number.

PRINTED TEXT: PAPER 1 TAC

94 30284

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RAYMOND EARL DAVIS, SR.				2. DATE OF DEATH MONTH DAY YEAR OCT. 12, 1994		3. TIME OF DEATH 6 20 P M	
4. SOCIAL SECURITY NUMBER 579-26-4545		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (in yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 13, 1925	
9a. FACILITY NAME (If not institution, give street and number) 804 OVERBROOK ROAD				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 804 OVERBROOK ROAD				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CREDIT MANAGER		16b. KIND OF BUSINESS/INDUSTRY W. R. GRACE CO.			
17. FATHER'S NAME (First, Middle, Last) LLOYD GRAHAM DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN EARL DORSEY			
19a. INFORMANT'S NAME (Type/Print) COLLEEN MAE DAVIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 OVERBROOK ROAD BALTIMORE, MD. 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEM. 10/15/94 BALTIMORE, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 10 mo	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, BPH						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>DZS</i>		29c. LICENSE NUMBER D37133		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DONNA L. DOW 6301 N. CHARLES STREET BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John E. Dolan</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30285

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLEONA E DEBERRY				2. DATE OF DEATH MONTH OCTOBER DAY 14 YEAR 1994		3. TIME OF DEATH 12:53 P M	
4. SOCIAL SECURITY NUMBER 091 12 6173		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 20 1919	
9a. FACILITY NAME (If not Institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Pennsylvania	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY =====		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 100 Jeffrey Street				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Worker		16b. KIND OF BUSINESS/INDUSTRY Garment Factory			
17. FATHER'S NAME (First, Middle, Last) Kimber Earnest				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie I. Hess			
19a. INFORMANT'S NAME (Type/Print) Donald Earnest				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Broadway Apt. 1 Milton, Pennsylvania 17847			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/17		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Zmijewski</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Chronic obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Diffuse Large Cell Lymphoma DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: HARBOR HOSPITAL CENTER 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Usha S. Hani</i> HOUSE OFFICER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/14/1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VENULAKONDA USHA SRIHARI HARBOR HOSPITAL CENTER BALTIMORE MD 21225							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30286

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Linda L. Davis</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>03</i> YEAR <i>94</i>		3. TIME OF DEATH <i>10:37 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-86-9107</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>33</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-18-1961</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MD</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i>	
9c. COUNTY OF DEATH <i>MD</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Balto</i>	
10c. CITY, TOWN OR LOCATION <i>Balto</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>3608 Spaulding Ave</i>	
10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Unknown</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Leon Davis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Barbara Thomas</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Daniel Parker</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5017 Denmore Ave Balto MD 21215</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>MT Zion Cemetery 10/15/94</i>		20c. LOCATION — City or Town, State <i>Lansdown, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F. H. West 4300 Wabash Ave</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Spontaneous Bacterial Peritonitis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Chronic liver disease</i>							Approximate Interval Between Onset and Death <i>6 days</i> <i>2 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pulmonary edema</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. DATE SIGNED (Month, Day, Year) <i>10/03/94</i>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>John March</i>		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Carstano Rivera Sinai Hospital of Baltimore, MD, 21215</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 15 1994</i>		32. REGISTRAR'S SIGNATURE <i>John March</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30287

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SOPHIA E DEFRANK				2. DATE OF DEATH MONTH DAY YEAR Oct 15 1994		3. TIME OF DEATH 5:20 pm	
4. SOCIAL SECURITY NUMBER 216321360		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 7, 1907	
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8022 OLD PHILADELPHIA ROAD				10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) =====		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) JOHN WAGNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET JACOBS			
19a. INFORMANT'S NAME (Type/Print) JOHN DeFRANK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 GARNETT ROAD JOPPA, MD 21085			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY REDEEMER		20c. LOCATION — City or Town, State 10/18 BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEHYDRATION							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 043134		29d. DATE SIGNED (Month, Day, Year) October 15, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH POLITO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLORIA S. DICKEY				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 4-55 P M	
4. SOCIAL SECURITY NUMBER 247-31-0876		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 25 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 27, 1969	
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1606 1601 Poplar Grove Street		10f. ZIP CODE 21216	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) Assembly Liner				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James McLoughlin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Dier Dickey			
19a. INFORMANT'S NAME (Type/Print) Alma McLoughlin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Poplar Grove Street Baltimore, MD 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Folmer</i>				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST END STAGE AIDS a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R. M. SHAH, MD				29c. LICENSE NUMBER D19668		29d. DATE SIGNED (Month, Day, Year) 10-10-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. M. SHAH, MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MT. GARDNER, CALIFORNIA

94 30289

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Melvin Gary Everetts				2. DATE OF DEATH MONTH 10 DAY 07 YEAR 94		3. TIME OF DEATH 12:40 a.m.	
4. SOCIAL SECURITY NUMBER 220-52-3344		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09 14 49	
9a. FACILITY NAME (If not institution, give street and number) 2028 Oakwood Lane				9b. CITY, TOWN OR LOCATION OF DEATH District Heights		9c. COUNTY OF DEATH P.G.	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION District Heights		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2028 Oakwood Lane				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1969 - 1974		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Engineer		16b. KIND OF BUSINESS/INDUSTRY Private	
17. FATHER'S NAME (First, Middle, Last) Roosevelt Everetts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Britt			
19a. INFORMANT'S NAME (Type/Print) Bessie Britt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2028 Oakwood Lane Dist. Hgts. Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Lincoln Memorial		20c. LOCATION — City or Town, State 10/15/94 Suitland, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George Edwards</i>				22. NAME AND ADDRESS OF FACILITY Hodges and Edwards 3910 Silver Hill Rd. Suitland, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure b. Myocardial infarction c. Kaposi Sarcoma d. Acquired Immune Deficiency Syndrome Approximate Interval Between Onset and Death 1 week 7 months 2 years 2 years Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Princy N Kumar MD</i>				29c. LICENSE NUMBER DC 17469		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Princy N Kumar MD; Georgetown University Medical Center, Washington DC							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30290

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH E. EVANS				2. DATE OF DEATH MONTH DAY YEAR 10 15 94		3. TIME OF DEATH a m 11:40	
4. SOCIAL SECURITY NUMBER 217-07-2054		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03 31 18	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 323 MARYLAND AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 323 MARYLAND AVENUE	
10f. ZIP CODE 21060				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR				16b. KIND OF BUSINESS/INDUSTRY MANUFACTURING			
17. FATHER'S NAME (First, Middle, Last) THOMAS L. EVANS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOLA FUNK			
19a. INFORMANT'S NAME (Type/Print) GLORIA J. DOWLING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 MARYLAND AVENUE—GLEN BURNIE, MD. 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY 10/19		20c. LOCATION — City or Town, State GLEN BURNIE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
23. PART I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Chronic Renal Insufficiency</i> <i>Pulmonary Edema</i>				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Cicchini MD</i>				29c. LICENSE NUMBER D40519		29d. DATE SIGNED (Month, Day, Year) 10/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MIRZA NUSAIRE M.D. 795 AQUAHART ROAD—GLEN BURNIE, MD. 21061							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30291

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marie Odessa Edwards</i>				2. DATE OF DEATH MONTH DAY YEAR <i>10-13-1994</i>		3. TIME OF DEATH <i>9:00 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>212-28-8695</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5-28-1913</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>3415 Cedarvale Rd</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N.C.</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>333 Whitridge Ave.</i>				10f. ZIP CODE <i>21218</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Ray Edwards</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mamie</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Judy Felton</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3415 Cedarvale Rd, Baltimore Md. 21218</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>Arbutus Mem Park 1/9</i>		20c. LOCATION - City or Town, State <i>BALTO CO, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2332 W. North Ave. BALTO MD 21218</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Carcinoma of the epiglottis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Carcinoma of the lung</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>3 years</i> <i>2 months</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Heart Failure</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. L. Brown Attending Physician</i>				29c. LICENSE NUMBER <i>D26534</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/14/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mare D. Sokolow, MD 301 St. Paul Place Baltimore MD 21202</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>Justin...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12302

ADMISSION

ADMISSION

ADMISSION

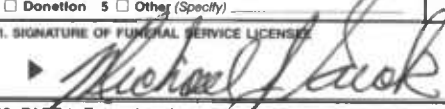


ADMISSION

ITEMS: 23 PART I, II, 27, 28a, b, c, d, e, f PER MEO G-717 11/4/94 reb

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOUGLAS RICHARD EVERING			2. DATE OF DEATH MONTH OCT DAY 13 YEAR 94		3. TIME OF DEATH 2:55 P.M.
4. SOCIAL SECURITY NUMBER 216-66-8939	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 37 YRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. 3, 1957		8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) ST AGNES HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Woodlawn		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4 J. McIntosh Court		10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Design Analyst		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last) George C. Evering			18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary L. Lee		
19a. INFORMANT'S NAME (Type/Print) Mr. George C. Evering			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4604 Langshire Road Baldwin, Maryland 21013		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corporation 10/17/94 Towson Maryland		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road 21214		
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. WATER INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO PSYCHOGENIC POLYDIPSIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SCHIZOPHRENIA					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10/13/94	28b. TIME OF INJURY UNKNOWN	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED WATER		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) P.O. BOX 21059 CATONSVILLE, MD.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.	
		29d. DATE SIGNED (Month, Day, Year) OCT 14, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30293

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Yvonne L. Ewell</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>9</u> YEAR <u>94</u>		3. TIME OF DEATH <u>0905 AM</u>	
4. SOCIAL SECURITY NUMBER <u>216-72-7916</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>36</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8 24 58</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University Hosp</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto.</u>		9c. COUNTY OF DEATH <u>MD</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>Balto.</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1005 Leadenhall Street</u>				10f. ZIP CODE <u>21230</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Also American</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>UAEmployed</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>UAEmployed</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>James E. Ewell</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Peggy Ann Jones</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Carolyn Burris</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3902 Rigde wood 21215</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Metro Crematory</u>		DATE		20c. LOCATION — City or Town, State <u>Catonsville, Md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Charles E. Hicks III</u>				22. NAME AND ADDRESS OF FACILITY <u>House of Rick F/H Annapolis Md.</u> <u>1922 Forest Dr.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>breast carcinoma</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <u>lung metastasis</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>liver metastasis</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <u>bone metastasis</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dehydration</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>William</u>				29c. LICENSE NUMBER <u>D13873</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/9/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Joseph Aisner MD 22 S. GREENE ST BALTIMORE MD 21201</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>				REGISTRAR'S SIGNATURE <u>John Anderson</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


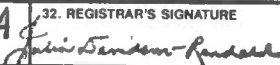
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30294

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leroy Henry ENDE, Sr.				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 1994		3. TIME OF DEATH 7:55 A M	
4. SOCIAL SECURITY NUMBER 218-03-3190		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1920	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1349 S. Seneca Road				10f. ZIP CODE 21220-4035		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Liberty Sheet Metal			
17. FATHER'S NAME (First, Middle, Last) Walter J. Ende				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Hoffman			
19a. INFORMANT'S NAME (Type/Print) Doris A. Ende				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1349 S. Seneca Road, Baltimore, Maryland 21220-4035			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Holly Hill Cemetery		DATE 10/15		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cholecystitis, urinary tract infection DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death 5 days 3 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Abbasi M.D.				29c. LICENSE NUMBER n/a		29d. DATE SIGNED (Month, Day, Year) 10-13-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mustafa Abbasi, MD 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30295

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES HEROY FRITZ				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 10:16 A M	
4. SOCIAL SECURITY NUMBER 217-32-7328		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 16, 1937	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Mt. Airy		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 415 Twin Arch Rd.				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouseman		16b. KIND OF BUSINESS/INDUSTRY Swanns Enterprises			
17. FATHER'S NAME (First, Middle, Last) Clarence P. Fritz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marian Brown			
19a. INFORMANT'S NAME (Type/Print) Mrs. Margaret Fritz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Twin Arch Rd. Mt. Airy, MD 21771			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Locust Grove Cemetery 10-15		20c. LOCATION — City or Town, State Mt. Airy, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayne				22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard W. Lewis, M.D.				29c. LICENSE NUMBER H43057		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cardiology Center 510 West 9th St. Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John S. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 in marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30296

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNIE FLOYD				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 3:35 A M	
4. SOCIAL SECURITY NUMBER 213-07-5091		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 106 YRS.		7. DATE OF BIRTH MONTH 3 DAY 27 YEAR 1888	
9a. FACILITY NAME (If not institution, give street and number) 1046 OLD NORTH POINT ROAD				9b. CITY, TOWN OR LOCATION OF DEATH nm./a		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4217 FULLERTON AVENUE				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) GRADE SCHOOL College (1-4 or 5+) -				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		15b. KIND OF BUSINESS/INDUSTRY VARIOUS	
17. FATHER'S NAME (First, Middle, Last) SCOTT SPEAKS				18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE HUTCHINSON			
19a. INFORMANT'S NAME (Type/Print) BLONDINIA COCKRELL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 FULLERTON AVENUE, BALTIMORE, MD 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) BALTIMORE CEMETERY 10-17		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Chapman</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. sepsis DUE TO (OR AS A CONSEQUENCE OF):							
b. urinary tract infection DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elliot N. EYAR MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliot N. EYAR MD Johns Hopkins Bayview Medical Center Baltimore, MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



61



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Fort, George</u> George Fort				2. DATE OF DEATH MONTH DAY YEAR <u>Oct 10 1994</u>		3. TIME OF DEATH <u>8:24 am</u>	
4. SOCIAL SECURITY NUMBER <u>214-76-3213</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug 11, 1914</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Sinai Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>		9c. COUNTY OF DEATH <u>Baltimore City</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>--</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore City</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>1803 Thornbury Rd.</u>			
10f. ZIP CODE <u>21209</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>none</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>None</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>George Fort</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Bertha Unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Ms. Jennifer Lochotzki</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1803 Thornbury Rd. Baltimore, MD 21209</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u>		20c. DATE <u>10-13</u>		20d. LOCATION — City or Town, State <u>Baltimore, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>John K Arnold</u>				22. NAME AND ADDRESS OF FACILITY <u>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. A Cardiac Arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. Atrial Fibrillation</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c. Mitral Stenosis</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d. Pneumonia</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>4 min</u> <u>10 y</u> <u>10 y</u> <u>10 d</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Paul A. Silver, MD</u>				29c. LICENSE NUMBER <u>A40102</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/10/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Paul A. Silver, MD, Sinai Hospital, Balt, MD 21209</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>Julia Anderson-Robert</u>			

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30298

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARREN E FIGGINS				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 11:15 PM M	
4. SOCIAL SECURITY NUMBER 216-64-6624		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/10/54	
8. BIRTHPLACE (State or Foreign Country) Virginia				9. FACILITY NAME (If not institution, give street and number) UNIVERSITY OF MD HOSPITAL		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
11. COUNTY OF DEATH BALTIMORE CITY				12. RESIDENCE OF DECEDENT		13. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. STATE MD		15. COUNTY Anne Arundel		16. CITY, TOWN OR LOCATION Deale		17. CITIZEN OF WHAT COUNTRY? USA	
18. STREET AND NUMBER P.O. Box 707, Herring Bay Road				19. ZIP CODE 20751		20. CITIZEN OF WHAT COUNTRY? USA	
21. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		27. KIND OF BUSINESS/INDUSTRY Painting			
28. FATHER'S NAME (First, Middle, Last) Warren B. Figgins				29. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Fogle			
30. INFORMANT'S NAME (Type/Print) Nancy M. Figgins				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 707, Deale, MD 20751			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery		34. DATE OATE		35. LOCATION — City or Town, State Annapolis, MD	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas D. Harkness				37. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PRIMARY PULMONARY HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jonathan F. J. MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, @, @*A, B, C, D, E, F PER MEO G-717 11/4/94 reb

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH W. GREENE		2. DATE OF DEATH MONTH OCT DAY 14 YEAR 94		3. TIME OF DEATH 11:25 A.	
4. SOCIAL SECURITY NUMBER 215-60-5307		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 7-19-54		8. BIRTHPLACE (State or Foreign Country) MD		9. FACILITY NAME (If not institution, give street and number) ST AGNES HOSPITAL	
10. STATE MD		10a. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		10b. COUNTY OF DEATH	
10c. STREET AND NUMBER 5922 LEEWOOD AVE		10d. ZIP CODE 21228		10e. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN	
16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) JOSEPH GREENE		18. MOTHER'S NAME (First, Middle, Maiden Surname) JOAN BENNETT	
19a. INFORMANT'S NAME (Type/Print) JOAN GREEN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5922 LEEWOOD AVE BALTO, MD 21228			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) WESTERN STAR CEMETERY		20c. LOCATION — City or Town, State 101894 CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i>		22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 10/13/94		28b. TIME OF INJURY found A. M.	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 100 BLOCK WESLEY AVE. BALTIMORE CO, MD.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) OCT 15, 1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John Benner-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30300

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Doris Gray</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>12</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1250 P M</i>	
4. SOCIAL SECURITY NUMBER <i>214-01-8068</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8/6/1916</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>301 McMechen Street Apt. 1026</i>				10f. ZIP CODE <i>21217</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yaa or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Waitress</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Merchants Club of Baltimore</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Lloyd Sheppard</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Cummings</i>			
19a. INFORMANT'S NAME (Type/Print) <i>George Gray</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>545 Myrtle Ave, 2F Brooklyn, New York 11205</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Auburn Cemetery 10/18/94</i>		20c. LOCATION — City or Town, State <i>Balto. Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <i>LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intracranial Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i></i> DUE TO (OR AS A CONSEQUENCE OF): b. <i></i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>				Approximate Interval Between Onset and Death <i>16 Hrs</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Neurosurgery</i>				29c. LICENSE NUMBER <i>6614</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/12/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>P. J. Roberts 22 S. Greene St, Balto, MD 21201</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John J. Neurosurgery</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG NO.

REG NO

1 DECEASED'S NAME (First, Middle, Last) JOSEPH GARY		2 DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1994		3 TIME OF DEATH 6:32 A	
4 SOCIAL SECURITY NUMBER 231-20-5398		5 SEX M	6 AGE (in yrs last birthday) 66	7 DATE OF BIRTH (Month, Day, Year) 5-1-28	8 BIRTHPLACE (State or Foreign Country) V.A.
9a FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL			9b CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c COUNTY OF DEATH
10 RESIDENCE OF DECEASED					
10a STATE MD.	10b COUNTY	10c CITY, TOWN OR LOCATION BALTO.		10d ZIP CODE 21205	
10e STREET AND NUMBER 1502 ELLWOOD AVE		10f ZIP CODE 21203		10g CITIZEN OF WHAT COUNTRY U.S.	
11 MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12 WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES		13 WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
14 RACE American Indian, Black, White, etc. BLACK		15 DECEASED'S OCCUPATION (Specify if work done during most of working life. Do NOT use retired) Retired			
16 DECEASED'S EDUCATION (Specify grade completed) Elementary/Secondary (K-12) College (1-4 or 5+)		17 DECEASED'S USUAL OCCUPATION (Specify if work done during most of working life. Do NOT use retired) BETH-Steel			
18 FATHER'S NAME (First, Middle, Last) William GARY			19 BROTHER'S NAME (First, Middle, Maiden Surname) Augusta Battle		
20 MOTHER'S NAME (First, Middle, Maiden Surname) Elsie GARY			21 MAILING ADDRESS (Street and number or Rural Route Number, City or town, State, Zip Code) 1502 ELLWOOD AVE BALTO. MD 21203		
22 METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Burial from State 4 <input type="checkbox"/> Other (Specify)		23 PLACE AND DATE OF DISPOSITION (Name of place, date, and other place) ARKBUTHS MEMPH		24 DATE 9/10/94	
25 SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia Battle		26 NAME AND ADDRESS OF FACILITY BETHS FUNERAL HOME 1129 N. LANSING ST			
27 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 2 hrs	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Coronary Heart Failure DUE TO (OR AS A CONSEQUENCE OF):		2 hrs	
		c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):		6 mo.	
		d. _____			
		e. _____			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
28 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
30. DATE OF INJURY (Month, Day, Year)		31. TIME OF INJURY		32. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
33. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34. LOCATION (Street and number or Rural Route Number, City or town, State)			
35. CERTIFIER (If more than one) 1 <input checked="" type="checkbox"/> MEDICAL EXAMINER: (On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
36. SIGNATURE AND TITLE OF CERTIFIER David E. Weng M.D.		37. LICENSE NUMBER 7444 60640		38. DATE SIGNED (Month, Day, Year) 10/12/94	
39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type Print) David E. Weng M.D. 600 N. WOLF ST. BALTIMORE MD 21205					
40. DATE FILED (Month, Day, Year) OCT 11 1994		41. REGISTRAR'S SIGNATURE David E. Weng			

94 30302

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Mitchell Grace				2. DATE OF DEATH MONTH DAY YEAR 10 - 15 - 94		3. TIME OF DEATH 9:48 PM	
4. SOCIAL SECURITY NUMBER 215-30-8465		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-05-32	
8. BIRTHPLACE (State or Foreign Country) IOWA				9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON	
9c. COUNTY OF DEATH BALTO.				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 435 Old Trail	
10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: White		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker	
16. KIND OF BUSINESS/INDUSTRY Own Home				17. FATHER'S NAME (First, Middle, Last) Lyle James Mitchell		18. MOTHER'S NAME (First, Middle, Maiden Surname) Regina Shea	
19a. INFORMANT'S NAME (Type/Print) Harry C. Grace				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Old Trail Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial		20c. LOCATION - City or Town, State 10/18 Lutherville, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis M00640	
22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner MD				29c. LICENSE NUMBER D25043		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, MD 2300 Dulaney Valley Road, Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Benison-Rudell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

THE NEW YORK PUBLIC LIBRARY

94-5914-510
B.K.S

94 30303

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) INEZ E. GILPIN				2. DATE OF DEATH MONTH DAY YEAR OCT. 14 94		3. TIME OF DEATH 1314 P M					
4. SOCIAL SECURITY NUMBER 212-01-4872		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/09/1916		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL E.R.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2936 Huntingdon Avenue				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) Homemaker		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Carlin M. Martin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther L. Williams							
19a. INFORMANT'S NAME (Type/Print) Pam Stewart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13537 Jarrettsville Pike Phoenix, Maryland 21131									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Memorial 10/18 Sykesville, Maryland		DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ripm Burger-Henss</i>		22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO inspection		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 15, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) OCT 17 1994 <i>John H. ...</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30304

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY ALICE GILLESPIE			2. DATE OF DEATH MONTH DAY YEAR Oct. 12, 1994		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER 236-26-1465	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. 15, 1911	8. BIRTHPLACE (State or Foreign Country) Va.	
9a. FACILITY NAME (If not institution, give street and number) 220 Spring Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Lutherville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lutherville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 220 Spring Ave.			
10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Day Manager		16b. KIND OF BUSINESS/INDUSTRY Joppa Fair Lanes			
17. FATHER'S NAME (First, Middle, Last) Thomas E. Widener			18. MOTHER'S NAME (First, Middle, Maiden Surname) Ora Belle Baker		
19a. INFORMANT'S NAME (Type/Print) Mrs. Betty Butcher			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Spring Ave. Lutherville, Md. 21093		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns. 10/15/94 Timonium, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Advanced Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Atrial Fibrillation</u> <u>Weightloss Malnutrition</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 37 J. Souweine MD		29c. LICENSE NUMBER 024732		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy Souweine M.D. 1134 York Rd. Lutherville, Md. 21093					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR REMAINING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30305

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES CAROL GARRISON				2. DATE OF DEATH MONTH OCTOBER DAY 13 , 1994 YEAR 1994		3. TIME OF DEATH 5:15 P M	
4. SOCIAL SECURITY NUMBER 218-28-9008		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-11-1931	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4227 Hickory Ave.				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) File Clerk		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) File Clerk		16b. KIND OF BUSINESS/INDUSTRY U. S. F. & G.			
17. FATHER'S NAME (First, Middle, Last) Vernon L. Garrison				18. MOTHER'S NAME (First, Middle, Maiden Surname) May Romig			
19a. INFORMANT'S NAME (Type/Print) Valerie Garrison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Camberley Circle, Towson, Maryland 21204			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) New Cathedral Cemetery 10-17-94		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Myelodysplastic Syndrome							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Long (MD) MOPHD Oncology Fellow				29c. LICENSE NUMBER M57E4		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. Scott Long, Dep't of Medical Oncology, JHH Baltimore MD.							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Garrison-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30306

ITEM: 7. PER F.H. FILM G-716 10/17/94 t.t.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD GREEN				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH 9:40A M	
4. SOCIAL SECURITY NUMBER 216-07-7184		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-08-94 1907	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD	
9c. COUNTY OF DEATH MD				10a. STATE MD		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 1905 Gwynn Falls Pkwy	
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintennace				16b. KIND OF BUSINESS/INDUSTRY Housing Authority			
17. FATHER'S NAME (First, Middle, Last) Richard E. Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Howard			
19a. INFORMANT'S NAME (Type/Print) Emma B Green				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Pennsylvania Ave. apt 610 Balto., MD 21217			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest 10-15 Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton				22. NAME AND ADDRESS OF FACILITY James A. Morton & sons 1701 Laurens St.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hypertension							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. J. B. Moshman				29c. LICENSE NUMBER 237299		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Harrison Rudek			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

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3

94 30307

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jeannette Gifford				2. DATE OF DEATH MONTH DAY YEAR Oct 13 1999		3. TIME OF DEATH 1:30 A.M.	
4. SOCIAL SECURITY NUMBER 002-16-1346		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/26/10	
9a. FACILITY NAME (If not institution, give street and number) Liberty Med. Center				9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto.	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER			
10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Cr2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unk		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) unk				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alphonine			
19a. INFORMANT'S NAME (Type/Print) Marion Muller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1185 Chester St. 21231			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metrol Cemetery		20c. LOCATION — City or Town, State Catonsville MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Miller				22. NAME AND ADDRESS OF FACILITY Jeff Miller #1639 N Broadway			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease							
DUE TO (OR AS A CONSEQUENCE OF): Large Left Pleural Effusion							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Arrhythmias Diabetes Mellitus							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) Oct 13, 1999			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.				29c. LICENSE NUMBER D41365			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights Ave							
31. DATE FILED (Month, Day, Year) OCT 17 1999				32. REGISTRAR'S SIGNATURE John...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5863-510
B.K.S

94 30308

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN GRALEWSKI				2. DATE OF DEATH OCT. 12 94		3. TIME OF DEATH 1222 P.M.							
4. SOCIAL SECURITY NUMBER 212-07-7165		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-28-1918		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) HOPKINS BAYVIEW MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH					
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 263 South East Avenue				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5 +)		16a. KIND OF BUSINESS/INDUSTRY Martin Marietta									
17. FATHER'S NAME (First, Middle, Last) Alexander Gralewski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Etanski									
19a. INFORMANT'S NAME (Type/Print) Betty Gralewski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 263 S. East Ave. Baltimore, MD 21224									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cem. 10/15		20c. LOCATION — City or Town, State Baltimore, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Elizabeth Selenski</i>				22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Home 700 S. Conkling St. Balto., MD 21224									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inquiry		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter A. Kelly</i>		29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 12, 1994							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) OCT 15 1994				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30309

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARA V. GIFFORD				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 0830A M	
4. SOCIAL SECURITY NUMBER 219-12-7551		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/7/24	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8909 AVONDALE RD.				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) HOUSEWIFE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOUSEKEEPING			
17. FATHER'S NAME (First, Middle, Last) HARRY WINFIELD DECKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE MAY THOMPSON			
19a. INFORMANT'S NAME (Type/Print) MICHAEL GIFFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 TALISTER CT. WHITE MARSH, MD. 21237			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 10/13/94		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home				22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME 7401 BELAIR ROAD BALTIMORE, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CARDIAC ARREST				Approximate Interval Between Onset and Death minutes	
		b. CHRONIC RENAL FAILURE				MONTHS	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c.					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABDOMINAL ANEURYSM.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Matthew H. W. W. W. W.				29c. LICENSE NUMBER D45757		29d. DATE SIGNED (Month, Day, Year) 10-12-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30310

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Regina Greenspon				2. DATE OF DEATH MONTH DAY YEAR Oct 6 1994		3. TIME OF DEATH 2:17 a M		
4. SOCIAL SECURITY NUMBER 220 40 6177		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 4 1915		
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 12615 Parkland Drive				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Manager		16. KIND OF BUSINESS/INDUSTRY Public School Systems				
17. FATHER'S NAME (First, Middle, Last) Samuel Singer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Schottig				
19a. INFORMANT'S NAME (Type/Print) Reuben K. Greenspon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12615 Parkland Drive Rockville Md 20853				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Menorah Gardens		DATE 10/9		20c. LOCATION — City or Town, State Rockville Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lisa D. Williams				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Home Falls Church Va 22046				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Endometrial Carcinoma								
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
b. Coronary Artery Disease c. Septic d.								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED				
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Emi A. Smith MD				29c. LICENSE NUMBER D24564		29d. DATE SIGNED (Month, Day, Year) 10/6/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Emi A. Smith MD 2730 University Blvd W#216 Wheaton Md 20902								
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John J. ...				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

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1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.

3. The third part is a description of the results
of the study, including the data collected and the
analysis performed.

4. The fourth part is a discussion of the results
and their implications, including a comparison with
previous studies.

5. The fifth part is a conclusion and a summary
of the findings of the study.

6. The sixth part is a list of references and a
list of figures and tables.

94 30311

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William W. Grainger Jr.				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 1994		3. TIME OF DEATH 6:25 A.M.	
4. SOCIAL SECURITY NUMBER 219-90-1176		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) 26 1978	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) Rayleigh Way 1309				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER Rayleigh Way 1309				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Student				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William W. Grainger Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia M. Wilson			
19a. INFORMANT'S NAME (Type/Print) Virginia M. Wilson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayleigh Way 1309 Balto, Md 21224			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakland		20c. DATE 10/15		20d. LOCATION — City or Town, State Dundalk, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark A. Ropach				22. NAME AND ADDRESS OF FACILITY W. Dabrowski / Chojnacki, F.A.R.A. 1005 Dundalk Ave. Balto, Md 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPHYXIA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST EPILEPSY / SEIZURES							Approximate Interval Between Onset and Death 20 minutes
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Peter W. Kaplan MD				29c. LICENSE NUMBER D34628		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) Peter W. Kaplan, Neurology Bayview 4940 E. Bayview Ave Baltimore 21224							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John William Rudolph			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5302-510

DWG

ITEMS: 27, 28a-f, PER MEO FILM G-720 2/6/95 t.t

ITEMS: 23 PART I, 27, PER MEO FILM G-716 10/28/94 t.t

94 30312

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARLON GALON		2. DATE OF DEATH MONTH DAY YEAR SEPT 14 94		3. TIME OF DEATH 2:54 P M	
4. SOCIAL SECURITY NUMBER 212-39-5157		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 22 YRS.	
7. DATE OF BIRTH (Month, Day, Year) MAY 28, 1972		8. BIRTHPLACE (State or Foreign Country) SURINAME, S.A.			
9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTO City	
RESIDENCE OF DECEDENT					
10a. STATE MD.		10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION SALISBURY	
10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 5294 EASTWOOD CIRCLE		10f. ZIP CODE 21801	
10g. CITIZEN OF WHAT COUNTRY? South America		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: SOUTHERN AMERICAN		14. RACE — American Indian, Black, White, etc. Specify: SO. AMERICAN		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT- 2yrs	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT & LABORER		16b. KIND OF BUSINESS/INDUSTRY SALIS. ST. UNIV. & PERDUE POULTRY FARMS.		17. FATHER'S NAME (First, Middle, Last) RONALD GALON	
18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA PALATA		19a. INFORMANT'S NAME (Type/Print) MARITA GALON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5294 EASTWOOD CIRCLE, SALISBURY, MD. 21801	
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) SURINAME, SO. AMERICA 9-24		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. Jolley</i>		22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road - Salisbury Jolley Memorial Chapels - MD 21801 (USA)			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DURING INTRA-OPERATIVE THUMB RECONSTRUCTION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 5-20-94		28b. TIME OF INJURY UNKNOWN	
28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED THUMB CRUSHED IN MACHINERY		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) PURDUE FARMS INC. WILLOW ST., SALISBURY, MD.	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Caron Lake MD</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) SEPT. 15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARLON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30313

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NATHANIEL MICHAEL JACOB HARTMANN				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 1994		3. TIME OF DEATH 6:15 P.M.	
4. SOCIAL SECURITY NUMBER 216-41-4185		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. -- MONTHS 6 DAYS 12 HOURS -- MIN. --		7. DATE OF BIRTH (Month, Day, Year) Mar 29, 1994	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 4315 Windy Hill Rd.			
9b. CITY, TOWN OR LOCATION OF DEATH Randallstown				9c. COUNTY OF DEATH Baltimore County			
10a. STATE MARYLAND		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Randallstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4315 Windy Hill Rd.				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) --		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) --		16b. KIND OF BUSINESS/INDUSTRY --			
17. FATHER'S NAME (First, Middle, Last) Andrew W. Hartmann				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Michel			
19a. INFORMANT'S NAME (Type/Print) Mr & Mrs Andrew W. Hartmann				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Windy Hill Rd. Randallstown, MD 21133			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 10-14		20c. LOCATION — City or Town, State Sykesville, MD		22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayres Jr.				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): CONGENITAL HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death 4 WEEKS SINGLE BIRTH	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M --		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Peter J. Mogayzel Jr., MD				29c. LICENSE NUMBER D45651		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER J. MOGAYZEL, JR., Johns Hopkins Hosp BALTIMORE							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John D. Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5859-510

blh

94 30314

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hamlin Winfield Holloman				2. DATE OF DEATH MONTH DAY YEAR Oct 12 1994		3. TIME OF DEATH M 0648	
4. SOCIAL SECURITY NUMBER 229-54-2487		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1/10/46	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 800 blk. Hilton Parkway		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3505 Milford Avenue	
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Driver				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver		16b. KIND OF BUSINESS/INDUSTRY A.B.F. Trucking Co.	
17. FATHER'S NAME (First, Middle, Last) Winfield Holloman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Aretha			
19a. INFORMANT'S NAME (Type/Print) Shirley Holloman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Milford Avenue Baltimore, MD 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 10/17		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10/12/94		28b. TIME OF INJURY 635 A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED motor vehicle collision		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 800 Black Hilton Parkway Baltimore, Md			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Oct 12 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS CHUTE, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-30315

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Shi-Shung Huang				2. DATE OF DEATH MONTH OCT. DAY 14 YEAR 94		3. TIME OF DEATH 4:30 P.M.	
4. SOCIAL SECURITY NUMBER 319-40-1730		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 16, 1934	
9a. FACILITY NAME (If not institution, give street and number) 1221 St. Andrews Way				9b. CITY, TOWN OR LOCATION OF DEATH Glenmont		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Glenmont		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1221 St. Andrews Way				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Taiwanese	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Doctor		18b. KIND OF BUSINESS/INDUSTRY Medicine			
17. FATHER'S NAME (First, Middle, Last) Ping				18. MOTHER'S NAME (First, Middle, Maiden Surname) Chiang			
19a. INFORMANT'S NAME (Type/Print) Margaret Huang				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 St. Andrews Way, Baltimore, Maryland 21239			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory		DATE 10/24		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John G. Reitz (M-00804)				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Celano MD				29c. LICENSE NUMBER D30929		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CELANO 6569 N Charles #205 BALT MD 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John J. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30316

Item # 9a,10e,19b Film # G 716 10-17-94 N.A Per Funeral Home

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Coe Hudson, Jr.				2. DATE OF DEATH MONTH DAY YEAR 10/12/1994		3. TIME OF DEATH 3:30 P. M.	
4. SOCIAL SECURITY NUMBER 216-30-5553		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04/22/1935	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH Pikesville		10. COUNTY OF DEATH Baltimore	
9a. FACILITY NAME (If not institution, give street and number) 1844 Reisterstown Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Pikesville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Pikesville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1844 Reisterstown Road		10f. ZIP CODE 21208	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Moving Company		17. FATHER'S NAME (First, Middle, Last) William Coe Hudson, Sr.	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Mahoney				19a. INFORMANT'S NAME (Type/Print) Lois Hudson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1844 Reisterstown Rd. 21208 18044 Reisterstown Road, Pikesville, MD	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial 10/15 Dorsey, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynn Burgee-Henss</i>				22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 21211 3631 Falls Road Baltimore, Maryland		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Esophageal cancer. Liver metastasis. Diabetes mellitus. Dilated cardiomyopathy.	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. C. Walker, MD</i>				29c. LICENSE NUMBER 830339		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Milan Wister, MD 19 WALKER AVE, BALTIMORE,				31. DATE FILED (Month/Day/Year) 10/13/94		32. REGISTRAR'S SIGNATURE <i>John E. ...</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30317

ITEM: 1. PER F.H. FILM G-716 10/17/94 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emily Hare EMILY VIRGINIA HARE				2. DATE OF DEATH MONTH DAY YEAR October 16 1994		3. TIME OF DEATH 8:30 AM	
4. SOCIAL SECURITY NUMBER 212-16-5004		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 29 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH				10a. STATE Maryland			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore City			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 5514 Plainfield Avenue			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Elmer Stambaugh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Naomi Johnson			
19a. INFORMANT'S NAME (Type/Print) Joan N. Koehler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Hillburn Ave. Baltimore, Md. 21214			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview United Meth. 10/19/94		20c. LOCATION — City or Town, State Sunnybrook Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr.	
22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214				23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Stroke Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. GI Bleed Approximate Interval Between Onset and Death 1 wk 2 wks 2 wks 1 wk			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Joan N. Koehler DO		29c. LICENSE NUMBER H 40531	
29d. DATE SIGNED (Month, Day, Year) 10/16/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Koehler Union Memorial Hosp. Balt MD			
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Sanderford			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30318

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gertrude Weyman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Oct 10 1994</i>		3. TIME OF DEATH HOURS MINUTES <i>7:00 P. M.</i>	
4. SOCIAL SECURITY NUMBER <i>358-07-1799</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 13, 1916</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Illinois</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>Virginia</i>		10b. COUNTY <i>Loudoun</i>	
10c. CITY, TOWN OR LOCATION <i>Sterling</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>606 Brethour Court</i>	
10f. ZIP CODE <i>20164</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Bookkeeper</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Medical Center</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Abraham Podkin</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Minnie Salkov</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Jerome Hyman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>606 Brethour Court, Sterling, Va. 20164</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King David Mem. Gdn. 10-12</i>		20c. LOCATION — City or Town, State <i>Falls Church, Va.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lisa D. Williams</i>				22. NAME AND ADDRESS OF FACILITY <i>Ives-Pearson Funeral Homes Falls Church, Va. 22046</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>RENAL FAILURE</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CARDIOMYOPATHY</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>SEVERE ANEMIA</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>BLEEDING DISORDER</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marlyn Clemmings MD PHYSICIAN</i>		29c. LICENSE NUMBER <i>D35791</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/11/94</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. VEMURY 9801 GEORGIA AVE, SILVER SPRING MD 20902</i>	
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-0000-0000 0000 0000

94 30319

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernard William Jones				2. DATE OF DEATH MONTH DAY YEAR Oct. 13 1994		3. TIME OF DEATH 10:30 A. M	
4. SOCIAL SECURITY NUMBER 227-10-3588		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1899	
8. BIRTHPLACE (State or Foreign Country) Virginia				9. COUNTY OF DEATH Anne Arundel			
9a. FACILITY NAME (If not institution, give street and number) 5252 Patrick Henry Drive				9b. CITY, TOWN OR LOCATION OF DEATH Brooklyn Park		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Brooklyn Park	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 5252 Patrick Henry Drive				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW I		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		17. KIND OF BUSINESS/INDUSTRY Steel			
17. FATHER'S NAME (First, Middle, Last) James Ernest Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Barbour			
19a. INFORMANT'S NAME (Type/Print) Mrs. Anna Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5252 Patrick Henry Dr. Brooklyn Park, MD 21225			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park 10/17		20c. LOCATION — City or Town, State Elkridge, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. A.S.C.D. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONDUCTION DEFECT - PERMANENT PACE MAKER							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D17753		29d. DATE SIGNED (Month, Day, Year) 10.14.1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K.S. DHARMASENA, MD 710 Church Street Brooklyn Park, MD 21225							
31. DATE OF DEATH (Month, Day, Year) OCT 17 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph Jennings</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Oct 10 1994</i>		3. TIME OF DEATH <i>10:24 M</i>	
4. SOCIAL SECURITY NUMBER <i>214-38-2191</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>52</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12-19-1941</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Md</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Md</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Woodlawn</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>6814 Fox Meadow Rd</i>	
10f. ZIP CODE <i>21207</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2415</i> College (14 or 5+) <i>2415</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Detective Sergeant</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Balti City Police Dept</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Joseph F. Jennings</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Doris Graves</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mildred Jennings</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6814 Fox Meadow Rd 21207</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet. 10/17/94</i>		20c. LOCATION — City or Town, State <i>Owings Mills, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Elron</i>				22. NAME AND ADDRESS OF FACILITY <i>March F. H. West 4300 Wabash Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>portal Hypertension with Hepatic encephalopathy</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Corrosion of liver from Alca/sof</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>1</i> DUE TO (OR AS A CONSEQUENCE OF): d.							
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined							
28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alina Hester</i>							
29c. LICENSE NUMBER <i>H43974</i>							
29d. DATE SIGNED (Month, Day, Year) <i>Oct 10 1994</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Northwest Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 15 1994</i>							
32. REGISTRAR'S SIGNATURE <i>John Benson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rev. Otis Katherine Johnson			2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 11:55 AM
4. SOCIAL SECURITY NUMBER 213-30-9892			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	7. DATE OF BIRTH (Month, Day, Year) 1/19/23
8. BIRTHPLACE (State or Foreign Country) N/A			9. FACILITY NAME (If not institution, give street and number) The Union Memorial Hospital Extended Care Unit Baltimore		
10a. STATE MD			10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER 1102 Montpelier Street		
10f. ZIP CODE 21218			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES N/A		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— H yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Restaurant Owner		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) N/A Otis Hood			18. MOTHER'S NAME (First, Middle, Maiden Surname) N/A Emma Rutledge		
19a. INFORMANT'S NAME (Type/Print) LEVOTA JOHNSON			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 Silverthorne Road/BALTIMORE, MD 21239		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. LOCATION — City or Town, State 10/18 ANNE ARUNDEL CO, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lee V. Holland			22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Dehydration					Approximate interval Between Onset and Death 2d 2d
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD HTN IDDM, recurrent UTI, PVD Neurogenic bladder, decubitus ulcer					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]			29c. LICENSE NUMBER D30717		29d. DATE SIGNED (Month, Day, Year) 10/12/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
31. DATE FILED (Month, Day, Year) OCT 17 1994 Jahid Abdul-Rasool					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEDENT'S NAME (First, Middle, Last) MARY JONES					2. DATE OF DEATH MONTH OCT DAY 13 YEAR 94		3. TIME OF DEATH 2:14 P.M.			
4. SOCIAL SECURITY NUMBER 213-34-3670		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	7. DATE OF BIRTH (Month, Day, Year) 2-24-32		8. BIRTHPLACE (State or Foreign Country) S.C.				
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL					9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT										
10a. STATE md		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTO.			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 722 N. LAKEWOOD AVE				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? US				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired			16b. KIND OF BUSINESS/INDUSTRY Nursing Asst.				
17. FATHER'S NAME (First, Middle, Last) William Moore					18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE RICE					
19a. INFORMANT'S NAME (Type/Print) Theresa Vance				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 N. LAKEWOOD AVE BALTO. MD 21205						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENLAND MEMPH. CEM. BALTO. MD			20c. LOCATION — City or Town, State BALTO. MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Beth Bitt					22. NAME AND ADDRESS OF FACILITY BETH'S FUNERAL HOME 1129 N. CAROLINE ST					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King					29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) OCT 14, 1994		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201										
31. DATE FILED (Month, Day, Year) OCT 17 1994					32. REGISTRAR'S SIGNATURE John Davidson-Randall					

94 30323

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS STANLEY JOHNSON II				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 9:30 P M	
4. SOCIAL SECURITY NUMBER 218-09-6412		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-15-17	
8a. FACILITY NAME (If not institution, give street and number) Stella Maris				8b. CITY, TOWN OR LOCATION OF DEATH Towson		8c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Glen Arm		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11630 Glen Arm Rd.				10f. ZIP CODE 21057		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Manager		15b. KIND OF BUSINESS/INDUSTRY Chevrolet Automotive			
17. FATHER'S NAME (First, Middle, Last) Thomas Stanley Johnson				16. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen A. Wardle			
19a. INFORMANT'S NAME (Type/Print) Thomas S. Johnson III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 4513, St. Augustine, Fl. 32085			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. LOCATION — City or Town, State 10-15 Parkville, Md.		20d. DATE 10-15	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROSTATE CANCER							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


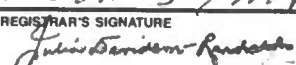
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30324

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Renaud N. Jacob				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 1202 M	
4. SOCIAL SECURITY NUMBER 217-32-0553		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/12/26	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) 1029 Friendship Rd		9b. CITY, TOWN OR LOCATION OF DEATH West River	
9c. COUNTY OF DEATH AA				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION 1029 Friendship Road, West River				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1029 Friendship Road	
10f. ZIP CODE 20778				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Veteran		16b. KIND OF BUSINESS/INDUSTRY Veterans Administration	
17. FATHER'S NAME (First, Middle, Last) William Frederick Jacob				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Anna Norris			
19a. INFORMANT'S NAME (Type/Print) Anne Marie Jacob				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 N. Beauregard Street, Alexandria, VA 22312			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Insufficiency DUE TO (OR AS A CONSEQUENCE OF): b. Diabetic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercholesterolemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones, MD Dept.				29c. LICENSE NUMBER DO6054		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America 21035							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30325

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN Wayne KYPER				2. DATE OF DEATH MONTH DAY YEAR 10 15 94		3. TIME OF DEATH 06:35 PM	
4. SOCIAL SECURITY NUMBER 185-24-4316		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1931	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 97 Mary Lane Apt. 103	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs. College (1-4 or 5+) 12 yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Cutter		16b. KIND OF BUSINESS/INDUSTRY Food Service	
17. FATHER'S NAME (First, Middle, Last) Wayne Kyper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet Householder			
19a. INFORMANT'S NAME (Type/Print) Sharon Swallow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 97 Mary Lane Apt. 103 Glen Burnie, MD 21061			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Pk. 11/18		20c. LOCATION — City or Town, State Glen Burnie, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cori L. Elanys				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of Larynx DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 38958		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DALJEET S. SIDHU, M.D./1413 ANNAPOLIS ROAD, #106/ODENTON, MD 21113							
31. DATE FILED FOR REGISTRATION OCT 17 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

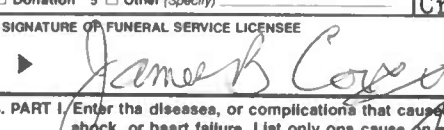
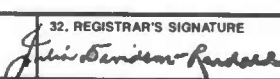
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30326

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Krause				2. DATE OF DEATH MONTH October DAY 13 YEAR 1994		3. TIME OF DEATH 1043 A M	
4. SOCIAL SECURITY NUMBER 214-12-2192		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/20/20	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1908 Oak Drive				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper		16. KIND OF BUSINESS/INDUSTRY Produce Market			
17. FATHER'S NAME (First, Middle, Last) Robert Kruger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Murphy			
19a. INFORMANT'S NAME (Type/Print) Walter Krause, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Oak Drive Baltimore, MD 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens		OATE 10/17/94		20c. LOCATION — City or Town, State Marriottsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOGENIC FAILURE							
a. DUE TO (OR AS A CONSEQUENCE OF):							
MYOCARDIAL INFARCTION							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, NON INSULIN DEPENDENT DIABETES							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Hoang, MD				29c. LICENSE NUMBER AT2438946		29d. DATE SIGNED (Month, Day, Year) October 13, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Vu Hoang, MD 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

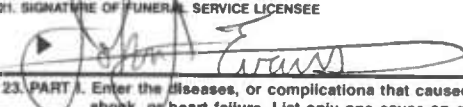

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30327

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROGER LENWEAVER KEACH SR.				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 2:08 P.M.	
4. SOCIAL SECURITY NUMBER 216-05-9860		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 6, 1914	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10408 Liberty Road				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Industrial Tool			
17. FATHER'S NAME (First, Middle, Last) Frank Lyman Keach				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Gertrude Fester			
19a. INFORMANT'S NAME (Type/Print) Mr. Roger Lenweaver Keach, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Goose Pond Drive Pasadena, MD 21122			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 10/13/94		20c. LOCATION — City or Town, State Sykesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → BRAIN METASTASES							
DUE TO (OR AS A CONSEQUENCE OF):							
b. LUNG CANCER							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner				29c. LICENSE NUMBER D 25643		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL R. FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30328

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERBERT A. KANE						2. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1994		3. TIME OF DEATH 12:54PM M		
4. SOCIAL SECURITY NUMBER 218-28-1093		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7. DATE OF BIRTH (Month, Day, Year) AUG. 31, 1932						8. BIRTHPLACE (State or Foreign Country) MARYLAND				
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MED. CTR						9b. CITY, TOWN OR LOCATION OF DEATH n/a			9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT										
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 2023 NORTHBOURNE ROAD						10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES AIRFORCE		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - College (14 or 5+) 1 YEAR				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER			16b. KIND OF BUSINESS/INDUSTRY POST OFFICE			
17. FATHER'S NAME (First, Middle, Last) WILBERT KANE						18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY WEAVER				
19a. INFORMANT'S NAME (Type/Print) VIVIAN WISE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4931 HERRING RUN DRIVE, BALTIMORE, MARYLAND #14				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY		DATE 10-17		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Chapman</i>						22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure.										
a. DUE TO (OR AS A CONSEQUENCE OF):										
b. Mitral Regurgitation										
c. DUE TO (OR AS A CONSEQUENCE OF):										
d. DUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal Cancer										
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Celano MD</i>						29c. LICENSE NUMBER D30923		29d. DATE SIGNED (Month, Day, Year) 10/13/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CELANO 6569 N Charles ST #205, BALT 21204										
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John A. Davidson</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30329

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAY KNOERLEIN				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 94		3. TIME OF DEATH 1715 M	
4. SOCIAL SECURITY NUMBER 213-05-5191		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 82 YRS.		7. DATE OF BIRTH MONTH 09 DAY 18 YEAR 12	
9a. FACILITY NAME (if not institution, give street and number) CHURCH HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE Md.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 716 South Bouldin Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housework		16b. KIND OF BUSINESS/INDUSTRY At Home			
17. FATHER'S NAME (First, Middle, Last) John Claude Rogers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Long			
19a. INFORMANT'S NAME (Type/Print) Claudia Picarello				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 S. Bouldin St. Balto., Md. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Sacred Heart of Jesus 10-17-94 Dundalk, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler		22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COPD, end stage Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atelectasis Pneumonia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER D. Navarro M.D. - Specialist				29b. LICENSE NUMBER D40356		29c. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. NAVARRO 100 N. Broadway, Balto. MD. 21231							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30330

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Gladys J. Knox</u>				2. DATE OF DEATH MONTH DAY YEAR <u>Oct 13 1994</u>		3. TIME OF DEATH <u>10:32 A M</u>	
4. SOCIAL SECURITY NUMBER <u>149-16-6762</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>87</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>10-17-06</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Joseph Richey Hospice</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>	
9c. COUNTY OF DEATH <u>Baltimore</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>3102 Auchentoroly Terr</u>	
10f. ZIP CODE <u>21217</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <u>James J. Johnson</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Martha Miller</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Charlotte Lee</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3717 Cornadore Rd. Baltimore Md 21244</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>ARVILLUS Memorial</u>		20c. LOCATION — City or Town, State <u>Baltimore Co. Md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph L. Russ</u>				22. NAME AND ADDRESS OF FACILITY <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balt. Md 21216</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Arrest</u> Approximate Interval Between Onset and Death <u>5 min</u>							
b. <u>Liver Metastases</u> DUE TO (OR AS A CONSEQUENCE OF): <u>2 mos</u>							
c. <u>Carcinoma Colon</u> DUE TO (OR AS A CONSEQUENCE OF): <u>3 mos</u>							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. LICENSE NUMBER <u>D4031</u>			
29c. SIGNATURE AND TITLE OF CERTIFIER <u>Daniel Finkelschtein</u>				29d. DATE SIGNED (Month, Day, Year) <u>10/13/94</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Daniel Finkelschtein Johns Hopkins Hosp Balt</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>John S. Anderson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100320 27 100320

100320 27 100320

94 30331

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Henry Kallinsky</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>10</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>12:30 PM</u>	
4. SOCIAL SECURITY NUMBER <u>577-07-8188</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Feb. 12, 1912</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Hebrew Home Of Greater Washington</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Rockville</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6121 Montrose Road</u>				10f. ZIP CODE <u>20852</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>8 Yrs</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Bread Distributor</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Arnold Bakery</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Frank Kallinsky</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ida Foland</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Frances K. Tettelbaum</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5800 Wilmett Road, Bethesda, Maryland 20817</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>King David Memorial Garden</u>		20c. LOCATION — City or Town, State <u>Falls Church, VA</u>		20d. DATE <u>10/11/1994</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Donald C. Stettinmyer</u>				22. NAME AND ADDRESS OF FACILITY <u>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.</u> <u>232 CARROLL ST, NW, WASHINGTON, DC 20012</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Status epilepticus</u> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <u>5 days</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Hypoxemia</u> DUE TO (OR AS A CONSEQUENCE OF):				<u>5 days</u>	
		c. <u>Ischemic cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF):				<u>Not known</u>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Penile carcinoma</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Burt I. Feldman MD</u>				29c. LICENSE NUMBER <u>D 23958</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/10/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>6121 Montrose Rd. Rockville, MD 20852</u> <u>Dr. Burt I. Feldman</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>		32. REGISTRAR'S SIGNATURE <u>John P. ...</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

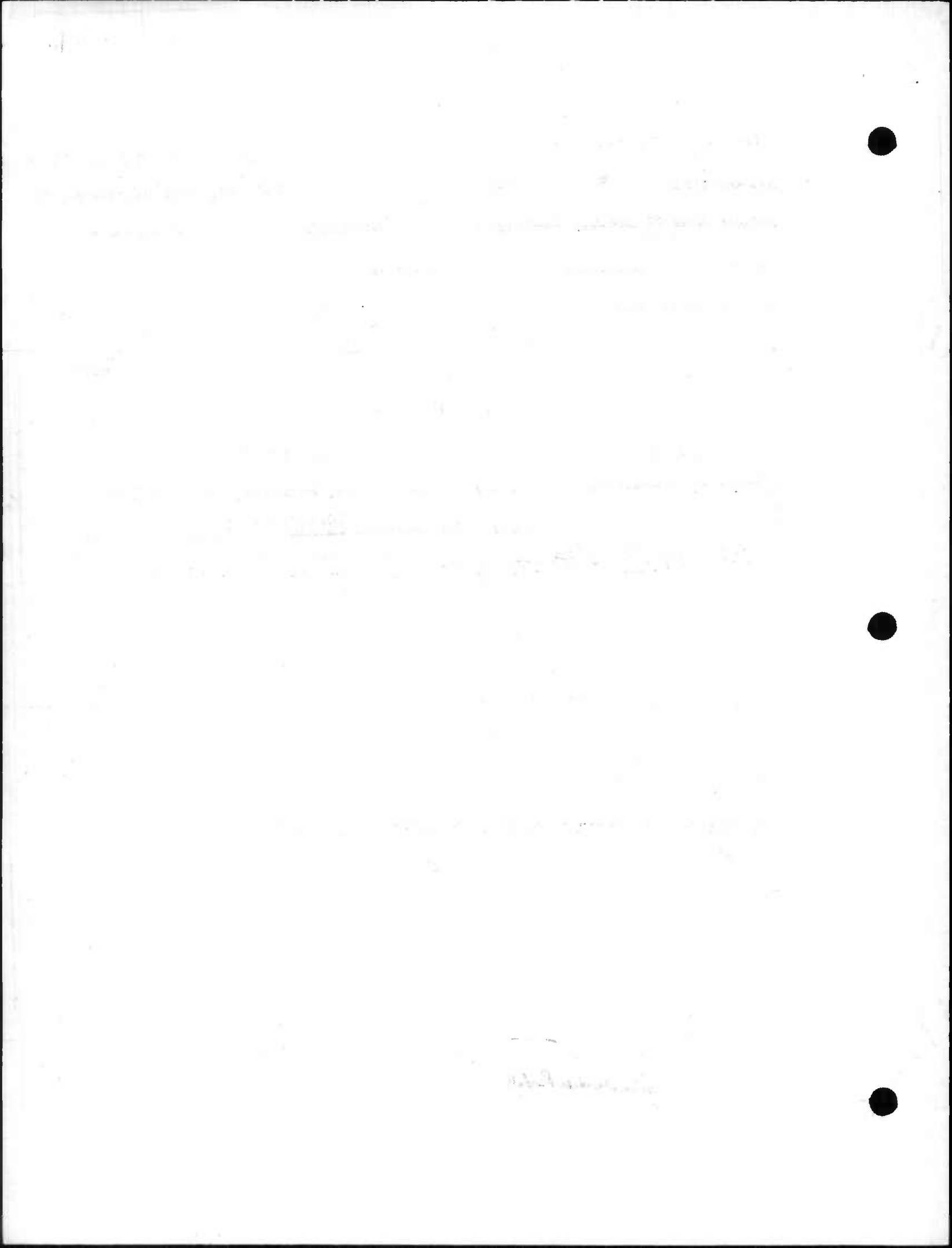
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30332

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John Kime</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>14</i> YEAR <i>1994</i>		3. TIME OF DEATH <i>3:28 A</i>	
4. SOCIAL SECURITY NUMBER <i>236-07-9771</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6 29 09</i>	
8. BIRTHPLACE (State or Foreign Country) <i>N. Carolina</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore, Md</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Md</i>			
10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>7433 Holabird Ave</i>	
10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 th</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Electrician</i>	
16b. KIND OF BUSINESS/INDUSTRY <i>Construction</i>		17. FATHER'S NAME (First, Middle, Last) <i>William A. Kime</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ida Seiler</i>		19a. INFORMANT'S NAME (Type/Print) <i>Thomas Kime</i>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7433 Holabird Ave Baltimore, Md 21222</i>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holly Hill</i>		20c. LOCATION — City or Town, State <i>10-17 Baltimore, Md</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Colt Connelly</i>		22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Dundalk 7110 Sollers Pt Rd 21222</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Myocardial Infarction</i> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Kidney Fracture</i>		Approximate Interval Between Onset and Death <i>6 days</i>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>10/7/94</i>		28b. TIME OF INJURY <i>? P M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>Fell picking up his dog</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>7433 Holabird Ave</i>		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>10/14/94</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Gallagher UMMS Dept. Med. 22 S. Green St. Balt. MD</i>	
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>		33. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.		TO BE COMPLETED BY FUNERAL DIRECTOR	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30333

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David Peter Larson				2. DATE OF DEATH MONTH 10 DAY 17 YEAR 94		3. TIME OF DEATH 1:25 a^m	
4. SOCIAL SECURITY NUMBER 124-38-1348		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05/23/47	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) 6321 Leith Walk		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH -----				10a. STATE Maryland		10b. COUNTY -----	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6321 Leith Walk				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Grounds Keeper		16b. KIND OF BUSINESS/INDUSTRY Golf Course			
17. FATHER'S NAME (First, Middle, Last) Kenneth Eugene Larson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Constance Olive Loveland			
19a. INFORMANT'S NAME (Type/Print) Sara Beth Whedbee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6321 Leith Walk Baltimore, MD 21239			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/17		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Mark Lamos MD		29c. LICENSE NUMBER D34521		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Lamos, M.D. 3346 Papermill Rd. Phoenix, MD 21131							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE John H. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


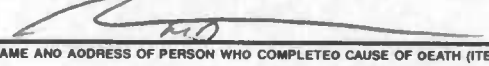
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22. 3. 1962

94 30334

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VINCENT LINDSAY				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 4:45 PM	
4. SOCIAL SECURITY NUMBER 215 01 7846		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-5-02	
8. BIRTHPLACE (State or Foreign Country) JAMAICA				9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH BALTIMORE CITY				10a. STATE MARYLAND		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 28 W. 27 TH STREET	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONG SHOREMAN		16b. KIND OF BUSINESS/INDUSTRY STEAM SHIP TRADE			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTELLA LINDSAY			
19a. INFORMANT'S NAME (Type/Print) LEOLA LINDSAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 W. 27 TH STREET, BALTIMORE, MARYLAND 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.) KING MEMORIAL PARK 10-15		20c. LOCATION — City or Town, State RANDALLSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH A VENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → URINARY TRACT INFECTION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): CORONARY HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARTURO MONTEIRO JR. 301 ST PAUL STREET, BALTIMORE, MD 21202							
31. DATE FILED (Month, Day, Year) OCT 17 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30335

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOTTIE P. LEE				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 12 1994		3. TIME OF DEATH 8:30 AM	
4. SOCIAL SECURITY NUMBER 219-22-3294		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 6, 1914	
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSP.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1359 PENTRIDGE ROAD				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSEMBLY WORKER		18b. KIND OF BUSINESS/INDUSTRY FULL BROTHERS			
17. FATHER'S NAME (First, Middle, Last) SANSTON M. FOSTER SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA ENNALS			
19a. INFORMANT'S NAME (Type/Print) LUCILLE BROWN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1359 PENTRIDGE ROAD, BALTIMORE, MARYLAND 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY 10-17		20c. LOCATION — City or Town, State ANNE ARUNDEL CO, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See Holland</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCHFH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): d. PNEUMONIA							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END-STAGE RENAL DISEASE HIP SURGERY							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. DATE SIGNED (Month, Day, Year) OCTOBER 12, 1994			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Adoo MD</i>							
29c. LICENSE NUMBER P-06723							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN ADOO, 5601 LOOT AVENUE BLVD, BALTO MD 21239							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Adoo</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30336

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>James Lewis</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>12</i> YEAR <i>94</i>		3. TIME OF DEATH <i>2:35 P M</i>	
4. SOCIAL SECURITY NUMBER <i>216-62-1238</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>40</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 4, 1953</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Bon Secours Hosp</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>1314 W. Lexington St.</i>				10f. ZIP CODE <i>21223</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Unemployed</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Clarence Henry Lewis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alverta S. Callaway</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Mary Callaway</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4306 Seminole Ave. Baltimore Md. 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, cemetery, crematory or other place) <i>Mt. Zion Cem</i>		20c. LOCATION — City or Town, State <i>Balto. Co. Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph F. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident, probable</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Hypertensive Cardiovascular disease</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul J. Murphy</i>		29c. LICENSE NUMBER <i>D26256</i>	
29d. DATE SIGNED (Month, Day, Year) <i>10/13/94</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>1940 W. Baltimore St Baltimore MD 21223</i>		31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>		32. REGISTRAR'S SIGNATURE <i>John S. ...</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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RECORD ROOM

RECORD ROOM

94 30337

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES MEREDITH				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 14, 1994		3. TIME OF DEATH 7:30 A M	
4. SOCIAL SECURITY NUMBER 219-10-7884		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 27, 1928	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) 1419 NORTHGATE ROAD		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1419 NORTHGATE ROAD	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CRANE OPERATOR		16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL			
17. FATHER'S NAME (First, Middle, Last) THOMAS MEREDITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE VALENTINE			
19a. INFORMANT'S NAME (Type/Print) LUCY A. TOOMER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1419 NORTHGATE ROAD/BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM. 10/18		20c. LOCATION — City or Town, State OWINGS MILLS, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>	
22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST		22. NAME AND ADDRESS OF FACILITY 1101 E. NORTH AVENUE/BALTIMORE, MD 21202		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BRAIN METASTASIS DUE TO (OR AS A CONSEQUENCE OF): CANCER OF THE LUNG DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death WEEKS MONTHS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC HEART DISEASE				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. C. Venetragion Jr. MD</i>			
29c. LICENSE NUMBER D13664				29d. DATE SIGNED (Month, Day, Year) 10/14/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. C. VENETRAGION JR. MD 1576 WENHITT BLVD. BALTO MD 21222							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30338

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Alice ELIZABETH Marks</i>				2. DATE OF DEATH MONTH DAY YEAR <i>10 11 1994</i>		3. TIME OF DEATH <i>n/a</i>	
4. SOCIAL SECURITY NUMBER <i>226-34-3230</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>MAY 24, 1929</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Nursing Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>BALTIMORE</i>	
10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>RANDALLSTOWN</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>9 SONYA COURT</i>				10f. ZIP CODE <i>21133</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5 TH</i> College (1-4 or 5+) <i>-</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>n/a</i>	
17. FATHER'S NAME (First, Middle, Last) <i>NICHOLAS MARKS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ZERA MARKS</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JAMES MARKS</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 SONYA COURT, RANDALLSTOWN, MD 21133</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK 10-15</i>		20c. LOCATION — City or Town, State <i>RANDALLSTOWN, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. East 1101 E. North Ave</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Vertical Arhythmia (Heart Block)</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Vertical Arhythmia (Heart Block)</i> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Heart Failure</i>							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D20964</i>		29d. DATE SIGNED (Month, Day, Year) <i>Oct. 13, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the bottom center of the page, possibly a signature or date.

94 30339

Item#17 Per F.H. Film# G-716 10/21/94 R.M.
 FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred C. Miller				2. DATE OF DEATH MONTH DAY YEAR October 15, 1994		3. TIME OF DEATH HOURS MIN. SEC. 3:00 am	
4. SOCIAL SECURITY NUMBER 212-80-6173		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 21, 1913	
9a. FACILITY NAME (If not institution, give street and number) 5818 Montgomery Road				9b. CITY, TOWN OR LOCATION OF DEATH Elkridge		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Elkridge		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5818 Montgomery Road				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) John F. O'Neill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie M. Degraft			
19a. INFORMANT'S NAME (Type/Print) June M. Rosemary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 Pelham Ave., Baltimore, Md. 21213			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 10/19		20c. LOCATION — City or Town, State Elkridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, MD 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Flowers M.D.</i>				29c. LICENSE NUMBER D20708		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Flowers M.D. 11055 Little Patuxent Pkwy Columbia, MD 21044							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30340

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE MERRITT				2. DATE OF DEATH MONTH DAY YEAR October 12, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216 14 8071		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/25/1910	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Bayview Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH --	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 29 Broadship Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Western Electric			
17. FATHER'S NAME (First, Middle, Last) Konstanty Celmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Kropkowski			
19a. INFORMANT'S NAME (Type/Print) Andrew Celmer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Riverside Ave (East) Baltimore, Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanilaus		20c. LOCATION — City or Town, State 10/15/94 Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY BRUZZDZINSKI FUNERAL HOME P.A. 1407 Eastern Ave. Baltimore Maryland 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARRHYTHMIA							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Atherosclerosis - Accelerated							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Diabetes Mellitus							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D44604		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael D. Suter, M.D. 9000 Franklin Sq. Dr. Balto, MD 21237							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Pauline G. Miller				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 9:59 A M	
4. SOCIAL SECURITY NUMBER 215-09-8214		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/24/908	
8. FACILITY NAME (If not institution, give street and number) Mercy Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Md.	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 524 N. Charles St. #1515				10f. ZIP CODE 21021		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use Retired.) Clerical		16b. KIND OF BUSINESS/INDUSTRY Rail Road			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) Mr. John O. Herrman, Esq.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 N. E 210 N. Charles St. Baltimore, Md. 21201			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 10/17/94 Pikesville, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Due to (or as a consequence of): a. Embolus Event Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joanna Chon MD.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joanna Chon MD 22 S. Greene St Balt MD 21201							
31. DATE OF DEATH (Month, Day, Year) Oct 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30342

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOWARD E. MILLER				2. DATE OF DEATH MONTH OCT DAY 13 YEAR 1994		3. TIME OF DEATH 0205 M	
4. SOCIAL SECURITY NUMBER 288-18-6307		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 22, 1924	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 359 Forelands Road				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales		16b. KIND OF BUSINESS/INDUSTRY Insurance	
17. FATHER'S NAME (First, Middle, Last) Charles Howard Miller I				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Cline			
19a. INFORMANT'S NAME (Type/Print) Sarah Jane Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Forelands Road, Annapolis, MD 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cem.		DATE		20c. LOCATION — City or Town, State Crownsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Pulmonary edema b. Acute inferior wall MI c. Coronary Artery Disease d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Barbara L. Bean MD				29c. LICENSE NUMBER D39497		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barbara L. Bean							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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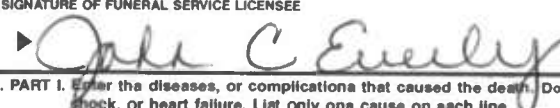
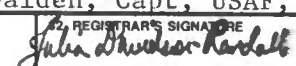
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94 30343

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Grace Hooper McNeal				2. DATE OF DEATH MONTH DAY YEAR Oct 10 94		3. TIME OF DEATH 4:04 a m	
4. SOCIAL SECURITY NUMBER 213-46-1873		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 5 1943	
8. BIRTHPLACE (State or Foreign Country) Indiana		9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Andrews AFB		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4219 Wickford Road		10f. ZIP CODE 21210	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1973 - 1991	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICER/REG NURSE		16b. KIND OF BUSINESS/INDUSTRY NURSING	
17. FATHER'S NAME (First, Middle, Last) Thomas F McNeal				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Hooper Smith			
19a. INFORMANT'S NAME (Type/Print) Catherine McN Larson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Cool Spring Dr. Alex. VA 22308			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery Oct 14 1994		20c. LOCATION — City or Town, State Baltimore MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Christine B. Walden				29c. LICENSE NUMBER 44884 VA		29d. DATE SIGNED (Month, Day, Year) 10 Oct 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christine B. Walden, Capt, USAF, MC				89 Medical Group Andrews AFB MD 20331-6600			
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30344

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John FRANCIS MURRAY			2. DATE OF DEATH MONTH 04 DAY 14 YEAR 94		3. TIME OF DEATH 4:15 AM
4. SOCIAL SECURITY NUMBER 018 37 2619	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 04/04/26
9a. FACILITY NAME (If not institution, give street and number) VA HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH MARYLAND
RESIDENCE OF DECEDENT					
10a. STATE MD	10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 1828 WILHELM AVE			10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) ---		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED		16b. KIND OF BUSINESS/INDUSTRY LABOR	
17. FATHER'S NAME (First, Middle, Last) MARTIN C. MURRAY			18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA DENK		
19a. INFORMANT'S NAME (Type/Print) VIOLA COCHRAN			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1828 WILHELM AVE ROSEDALE, MD 21237		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA 10/17 BALTIMORE, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic colon carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Anemia Congestive heart failure					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28e. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER Martin E. English MD		
29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year) 10/14/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN E. ENGLISH 22 GREENE ST BALTIMORE MD 21201					
31. DATE FIED (Month, Day, Year) OCT 17 1994					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item#3,4,9c,10b,13,16a,16b,20a,24b,29 Film#717(11/04/94 30345

Item#19b,19a(Per F.H.) Film# G-716 10/21/94 R.M.⁹⁴)FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARJORIE F. MCNAIR		2. DATE OF DEATH MONTH DAY YEAR October 6, 1994		3. TIME OF DEATH 6:00 P M	
4. SOCIAL SECURITY NUMBER 213-30-8706 213-30-8700		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Dec 3, 1935		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) 5805 Gwynn Oak Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Maryland		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5805 Gwynn Oak Avenue		10f. ZIP CODE 21207	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> College 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VOCATIONAL REHABILITATION SPEC. Rehab Counselor		16b. KIND OF BUSINESS/INDUSTRY MARYLAND STATE DEPT. OF EDUCATION State of Maryland	
17. FATHER'S NAME (First, Middle, Last) Dave Frazier		18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Parker			
19a. INFORMANT'S NAME (Type/Print) TONI V. MCNAIR Lucretia McNair		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3427 YATARUBA DRIVE 2815 Boardman Avenue Baltimore, MD 21215			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 10/10		20c. LOCATION — City or Town, State Baltimore County, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bayard L. Follieri		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 3 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TYPE OF CERTIFIER J. Downs MO		29c. LICENSE NUMBER D33624	
29d. DATE SIGNED (Month, Day, Year) 10/10/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN C. DOWNS, MD 7505 OSLER DRIVE, STE 504 TOWSON, MD 21204			
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE John C. Downs			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30346

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Irene Frances Moore				2. DATE OF DEATH MONTH 10 DAY 9 YEAR 94		3. TIME OF DEATH 12:00 P M	
4. SOCIAL SECURITY NUMBER 216-34-3049		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1937	
9a. FACILITY NAME (If not Institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH baltimore	
RESIDENCE OF DECEASED							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3327 Alto Road				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? usa	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Social Security Administa.	
17. FATHER'S NAME (First, Middle, Last) Vernon Savage				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottena Johnson			
19a. INFORMANT'S NAME (Type/Print) Thomas Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3327 Alto Road Baltimore, MD 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison 10/13		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ray L. Folmer</i>				22. NAME AND ADDRESS OF FACILITY Nuter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LIVER AND BONE METASTASES DUE TO (OR AS A CONSEQUENCE OF): b. ADENOCARCINOMA, UNKNOWN PRIMARY mos. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R Faulkner</i>				29c. LICENSE NUMBER 225643		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. Kendall Faulkner 2300 Dulany Valley Road Towson, MD 21204							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) HENRY		2. DATE OF DEATH MONTH 10 DAY 11 YEAR 94		3. TIME OF DEATH 1320	
4. SOCIAL SECURITY NUMBER 215 28 4217		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.	
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 35 N. PATTERSON PARK AVENUE		10f. ZIP CODE 21231	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES MARINES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 TH College (1-4 or 5+) -	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY SPARROWS POINT		17. FATHER'S NAME (First, Middle, Last) HERBERT NEWBORN	
18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA HARRIS		19a. INFORMANT'S NAME (Type/Print) VIVIAN NEWBORN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 N. PATTERSON PARK AVE, BALTIMORE, MARYLAND	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 10-15		20c. LOCATION — City or Town, State BALTIMORE co, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Terminal Lung Ca c mets Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10/11/94	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Med. Specialist		29c. LICENSE NUMBER D40356		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. NEWBORN 100 N. Broadway Balto. MD. 21231		31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 	

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MEMORANDUM

MEMORANDUM

TO THE ASST

SAINTING

SAINTING

LIBRARY

LIBRARY

RECEIVED FEB 1 1950

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94 30348

item # 19b File # G 716 10-17-94 N.A. Pre Funeral Home

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ada Nelson				2. DATE OF DEATH MONTH Oct DAY 12 YEAR 1994		3. TIME OF DEATH 12:30 P.M.	
4. SOCIAL SECURITY NUMBER 220-30-1171		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 4, 1908	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Liberty Medical Center			
10. STATE Maryland				10b. COUNTY Baltimore			
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3901 Fairview Avenue				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper		15b. KIND OF BUSINESS/INDUSTRY Catholic Daughters of America			
17. FATHER'S NAME (First, Middle, Last) Frank Turner				16. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Byrd			
19a. INFORMANT'S NAME (Type/Print) Ada B. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4120 Fairfax A Road Baltimore, Maryland 21216					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. LOCATION — City or Town, State 10/17 Baltimore County, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gayle Folch</i>	
22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc.		22. ADDRESS OF FACILITY 2501 Gwynns Falls Parkway Baltimore, Maryland 21216					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.		29c. LICENSE NUMBER D41365		29d. DATE SIGNED (Month, Day, Year) Oct 12, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. Liberty Medical Center							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

84000 20

NEW YORK

Consistent Heart Failure

Proctor, H. L.

308140

Oct 11 1936

94 30349

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FREDERICK J. OSTER				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94 TIME OF DEATH 02:00 PM				3. TIME OF DEATH 02:00 PM	
4. SOCIAL SECURITY NUMBER 214-30-6415		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02 14 33		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH A.A. COUNTY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 401 WISTFUL VISTA COURT				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN CONFLICT		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 02				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) POLICE OFFICER			16b. KIND OF BUSINESS/INDUSTRY PUBLIC SAFETY		
17. FATHER'S NAME (First, Middle, Last) STANLEY L. OSTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA E. FOSS					
19a. INFORMANT'S NAME (Type/Print) CAROLYN L. OSTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 WISTFUL VISTA CT-GLEN BURNIE, MD. 21061					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) METRO CREMATORY, INC. 10/18			20c. LOCATION — City or Town, State CATONSVILLE, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Lung - Metastatic DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Heart Disease Seizure disorder DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D38958			29d. DATE SIGNED (Month/Day/Year) 10/15/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DALJEET S SIDHU, M.D./1413 ANNAPOLIS RD/ODENTON, MD 21113									
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CYNTHIA PULLEY			2. DATE OF DEATH MONTH DAY YEAR OCT. 07, 1994		3. TIME OF DEATH 8:41 PM						
4. SOCIAL SECURITY NUMBER 212-92-2770		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 30 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 31, 1964		8. BIRTHPLACE (State or Foreign) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH n/a					
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 5925 BELLONA AVENUE			10f. ZIP CODE 21212			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (1-4 or 5+) -			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed			16b. KIND OF BUSINESS/INDUSTRY n/a					
17. FATHER'S NAME (First, Middle, Last) ULYSSES PULLEY			18. MOTHER'S NAME (First, Middle, Maiden Surname) BEVERLY WEBB								
19a. INFORMANT'S NAME (Type/Print) SHEILA PULLEY			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 N. ELLWOOD AVENUE, BALTIMORE, MARYLAND 21205								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL PARK 10-14		20c. LOCATION — City or Town, State DUNDALK, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jessica Chapman</i>			22. NAME AND ADDRESS OF FACILITY WM. C. MARCHE H.-1101 E. NORTH AVENUE								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST s. MASSIVE INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. COCAINE ABUSE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATITIS C, HEPATITIS B, PPD+						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) Found 10-7-94		28b. TIME OF INJURY unknown		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED subject says took drugs		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 5921 Bellona Ave Baltimore, Md							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis Chute M.D.</i>		29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. , 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201						31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John Shuler Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

St. George's Bay, N.S.W.

94 30351

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MRS. CHARLES ELLIE PERRY				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1994		3. TIME OF DEATH n/a M	
4. SOCIAL SECURITY NUMBER 212-20-9898		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 29, 1924	
8. BIRTHPLACE (State or Foreign Country) S. Carolina				9a. FACILITY NAME (If not institution, give street and number) 947 N. Washington Street		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 947 N. Washington Street	
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dietary		16b. KIND OF BUSINESS/INDUSTRY Johns Hopkins Hospital	
17. FATHER'S NAME (First, Middle, Last) Charles Butler LittleJohn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Atlanta Brown			
19a. INFORMANT'S NAME (Type/Print) James Perry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 947 N. Washington Street/Baltimore, MD 21205			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, other place) GARRISON FOREST VA CEMETERY		20c. LOCATION — City or Town, State 10-17 OWINGS MILLS, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 9 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lacunar cerebral infarction Hypertension DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen B. Grober MD				29c. LICENSE NUMBER MS670		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen B. Grober, M.D. Johns Hopkins Hospital 600 North Wolfe St. Baltimore, Maryland 21287							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE Julia Anderson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item # 1 Film # J 716 10-17-94 N.A. Per Funeral Home Item # 2

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JAMES FITZGERALD				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 9:55 P.M.	
4. SOCIAL SECURITY NUMBER 212-86-4581		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 13	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Apr. 20, 1966	
8. BIRTHPLACE (State or Foreign Country) S. Carolina				9. COUNTY OF DEATH N/A			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4822 GREENCREST ROAD				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16. KIND OF BUSINESS/INDUSTRY WELCH REMODELING			
17. FATHER'S NAME (First, Middle, Last) BOOKER T. WASHINGTON RICE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY PEAY			
19a. INFORMANT'S NAME (Type/Print) MARY PEAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4822 GREENCREST ROAD/BALTIMORE, MD 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY		DATE 10/17		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See W. Bolland</i>				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVE./BALTIMORE, MD 21202			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wounds (2) of chest and Left Leg DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10/13/94		28b. TIME OF INJURY 2:47 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street		28d. DESCRIBE HOW INJURY OCCURRED Subject shot					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) See Druid Peak Lake Drive		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 14, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30353

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Preudhomme				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 4:32 P.M.	
4. SOCIAL SECURITY NUMBER 213-62-5016		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-26-24	
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH USA	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 5415 Lothian Road			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 <input checked="" type="checkbox"/> Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber		16b. KIND OF BUSINESS/INDUSTRY Plumbing			
17. FATHER'S NAME (First, Middle, Last) James Preudhomme				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane Charles			
19a. INFORMANT'S NAME (Type/Print) Patricia Preudhomme				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Lothian Road Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery 10/17		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis		22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypoxia - Respiratory insufficiency DUE TO (OR AS A CONSEQUENCE OF): ARDS (adult respiratory distress syndrome) DUE TO (OR AS A CONSEQUENCE OF): Right pneumonectomy DUE TO (OR AS A CONSEQUENCE OF): Cancer right lung Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vascular hypertension History of Smoking DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Hafiz Zrebeet, M.D., Ph.D.		29c. LICENSE NUMBER D-33583		29d. DATE SIGNED (Month, Day, Year) 10-16-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hafiz Zrebeet 2600 Liberty Heights Baltimore Md							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30354

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert A. Payne				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 217-16-6713		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-8-1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3711 Clipper Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH --				10a. STATE Maryland			
10b. COUNTY --				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3711 Clipper Road			
10f. ZIP CODE 21211				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Police Detective		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Detective		16b. KIND OF BUSINESS/INDUSTRY Law Enforcement			
17. FATHER'S NAME (First, Middle, Last) Robert C. Payne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ann Ward Payne			
19a. INFORMANT'S NAME (Type/Print) Toby M. Thompson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Clipper Road Baltimore, MD 21211			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. 10/17		20c. LOCATION — City or Town, State Balto., MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Rd Balto., MD 21211		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Malignant Mesothelioma. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Dr. Brian Bohner				29c. LICENSE NUMBER D43489		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Brian Bohner							
31. DATE FILED (Month, Day, Year) OCT 15 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30356

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth R. Pettit				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 4 am	
4. SOCIAL SECURITY NUMBER 216-24-4050		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5/7/21	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. COUNTY OF DEATH Baltimore, MD			
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD			
10a. STATE MD				10b. COUNTY Balt.		10c. CITY, TOWN OR LOCATION MD	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER North Charles St. 524 Apt 818			
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Receptionist		16b. KIND OF BUSINESS/INDUSTRY Office work			
17. FATHER'S NAME (First, Middle, Last) Shugard				18. MOTHER'S NAME (First, Middle, Maiden Surname) McCart			
19a. INFORMANT'S NAME (Type/Print) Jay Cohen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Centre St. 23 Balto., Md. 21202			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn		20c. LOCATION — City or Town, State 19/17 Dandalk, Md.		20d. DATE 19/17	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark A. Rappach				22. NAME AND ADDRESS OF FACILITY W. Dabrowski-Chojnacki, F.H. P.A. 1005 Dandalk Ave. Balto., Md 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joanna Chon MD				29c. LICENSE NUMBER A44174 35AC2731		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joanna Chon 22 S. Greene St Baltimore MD 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHRISTINA C. PARKER			2. DATE OF DEATH MONTH DAY YEAR OCTOBER 10 1994		3. TIME OF DEATH 10:37 A.M.					
4. SOCIAL SECURITY NUMBER 213-41-9277		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 9 9 9		7. DATE OF BIRTH (Month, Day, Year) 1-4-1994		8. BIRTHPLACE (State or Foreign Country) Md		
9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH BALTIMORE				
10a. STATE Md			10b. COUNTY			10c. CITY, TOWN OR LOCATION Woodstock			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2759 Melrose Avenue			10f. ZIP CODE 21163			10g. CITIZEN OF WHAT COUNTRY? U S A				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown			16b. KING OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) Herbert J. Green			18. MOTHER'S NAME (First, Middle, Maiden Surname) Christine Parker							
19a. INFORMANT'S NAME (Type/Print) Christine Parker			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 W. Forest Park Avenue Balto, Md 21207							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park		DATE 10/15/94		20c. LOCATION — City or Town, State Randallstown, Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Pattia Ebron			22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Drowning Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10/10/94		28b. TIME OF INJURY 0930 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED Submerged in tub		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Karen Lake MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCTOBER 11, 1994				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jaron Lake MD 111 Penn Street, Baltimore, Maryland 21201										
31. DATE FILED (Month, Day, Year) OCT 15 1994		32. REGISTRAR'S SIGNATURE John Anderson-Randall								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, of item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>WILLIAM POWELL</i>				2. DATE OF DEATH MONTH DAY YEAR <i>10-11-94</i>		3. TIME OF DEATH <i>2:30AM</i>	
4. SOCIAL SECURITY NUMBER <i>229-01-4989</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12-21-19</i>	
8. BIRTHPLACE (State or Foreign Country) <i>VIRGINIA</i>				9a. FACILITY NAME (If not institution, give street and number) <i>MERIDIAN MULT MEDICAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>TOWSON, MD</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>4020</i>	
10f. ZIP CODE <i>21207</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> College (1-4 or 5+) <i>Steel Worker</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Steel Worker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel Corporation</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Armstead H. Powell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bessie Walthal</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ella Clanton</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1208 Meridene Drve Baltimore, MD 21239</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park 10/14</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin Parker</i>				22. NAME AND ADDRESS OF FACILITY <i>Nutter Funeral Home Inc. 2501 Gwynn Falls Pky Baltimore, Maryland 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic colon cancer</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Prostate cancer</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Gaber</i>		29c. LICENSE NUMBER <i>D23964</i>	
29d. DATE SIGNED (Month, Day, Year) <i>10/11/94</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jeffrey Gaber, MD 2360 W. JOPPA RD #302 LUTHERVILLE, MD 21093</i>			
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. Hurd</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5765-510
A.S.P

94 30358

ITEMS: 23 PART I 27 PER MEO G-717 11/4/94 reb

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARENCE S. RICHARDSON				2. DATE OF DEATH MONTH DAY YEAR OCT. 6 94		3. TIME OF DEATH 9:12 A M	
4. SOCIAL SECURITY NUMBER 237-44-4594		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH MONTH DAY YEAR AUG. 21, 1933	
8. BIRTHPLACE (State or Foreign Country) N. CAROLINA				9a. FACILITY NAME (If not institution, give street and number) 1821 freedom way		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND			
10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1821 FREEDOM WAY-NORTH				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) YARD FOREMAN		16b. KIND OF BUSINESS/INDUSTRY ERDMAN LENDER COMPANY	
17. FATHER'S NAME (First, Middle, Last) LOUIE RICHARDSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA MC GREGORY			
19a. INFORMANT'S NAME (Type/Print) IDA R. BLANEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 N. MILTON AVENUE, BALTIMORE, MARYLAND #05			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) GARRISON FOREST VA CEMETERY 10-12 OWINGS MILLS, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. SEIZURE DISORDER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 6, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARKED F. GOLLO, JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 20c, PER F.H. FILM G-717 11/16/94 t.t

94 30359

ITEMS: 23 PART I, 27, 28a,b,c,d,e,f PER MEO G-717 11/4/94 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORIAN ANTHONY RUSSELL				2. DATE OF DEATH MONTH OCT. DAY 09 YEAR 1994		3. TIME OF DEATH 7:00 P M	
4. SOCIAL SECURITY NUMBER n/a		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 1 MONTHS 15 DAYS 15 HOURS 15 MIN.		7. DATE OF BIRTH (Month, Day, Year) AUG. 27, 1994	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) BREEZY TREE COURT		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION TIMONIUM	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4J BREEZE BRANCH COURT		10f. ZIP CODE 21093	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) -	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BABY				16b. KIND OF BUSINESS/INDUSTRY n/a		17. FATHER'S NAME (First, Middle, Last) MICHAEL RUSSELL	
18. MOTHER'S NAME (First, Middle, Maiden Surname) YOLANDA WRIGHT				19a. INFORMANT'S NAME (Type/Print) YOLANDA RUSSELL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4J BREEZE BRANCH COURT, TIMONIUM 21093	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY CEMETERY 10-14		20c. LOCATION — TIMONIUM, MD. ANNE ARUNDEL CO, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jessad Chapman</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPHYXIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) FOUND IN A DUMPSTER			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) FOUND 10/9/94		28b. TIME OF INJURY found at 7:00 P.	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED SUBJECT FOUND IN DIAPER BAG		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND IN DUMPSTER	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 14 BREEZY TREE CT. BALTIMORE CO. MD.				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margarita Korell</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT. 10, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE OF DEATH (Month, Day, Year) OCT 11 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30360

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>John Rau, Sr.</u>		2. DATE OF DEATH <u>10-13-94</u>		3. TIME OF DEATH <u>2:47</u> A.M.	
4. SOCIAL SECURITY NUMBER <u>213-26-2599</u>		5. SEX <u>1</u> M <u>2</u> F		6. AGE (In yrs. last birthday) <u>65</u> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <u>November 29, 1928</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>4376 Parkton St.</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <u>Md.</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO		10e. STREET AND NUMBER <u>4376 Parkton St.</u>		10f. ZIP CODE <u>21229</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS <u>2</u> Married 1 Never Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES <u>Korean</u>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>9</u> Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Clerk</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Sunpapers</u>	
17. FATHER'S NAME (First, Middle, Last) <u>William E. Rau, Sr.</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Agnes O'Brien</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mary Louise Rau</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4376 Parkston St., Baltimore, Md. 21229</u>			
20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Crest Lawn Memorial Grdns. 10/15</u>		20c. LOCATION — City or Town, State <u>Sykesville, Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Gary L. Kaufman</u>		22. NAME AND ADDRESS OF FACILITY <u>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metastatic Merkel Cell Carcinoma</u>					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)			
27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dorothy A. Snow, M.D.</u>		29c. LICENSE NUMBER <u>024149</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/13/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <u>Dorothy A. Snow, M.D. to N. Greene St., Baltimore, Maryland 21201</u>					
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30361

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEASED'S NAME (First, Middle, Last) Esther Redd				2. DATE OF DEATH 09 24 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 227-16-9058		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09 20 16	
8. BIRTHPLACE (State or Foreign Country) VA				9. CITY, TOWN OR LOCATION OF DEATH Baltimore		10. COUNTY OF DEATH	
9a. FACILITY NAME (If not institution, give street and number) Trinity Nursing Home							
10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 4213 Groveland Avenue		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? U.S.				11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4	
16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Activist				17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Bernard Walton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Poole			
19. INFORMANT'S NAME (Type/Print) Nathaniel Redd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Groveland Avenue Balto., MD. 21215			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Pk. 9/27/94		20c. LOCATION — City or Town, State Arbutus, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. L. Redd</i>				22. NAME AND ADDRESS OF FACILITY 1721-27 N. Montrose ST. Redd Funeral Service Balto., MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration pneumonia massive CVA IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D37573		29d. DATE SIGNED (Month, Day, Year) 10/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeff Zibell MD 7220 Park Heights Ave. Baltimore MD 21208							
31. DATE FILED (Month, Day, Year) OCT 17 1994							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LIVIA				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1994				3. TIME OF DEATH M 8:26A			
4. SOCIAL SECURITY NUMBER 216-54-5386		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-31-53		8. BIRTHPLACE (State or Foreign Country) NY			
9a. FACILITY NAME (If not institution, give street and number) 2215 EAST CHASE STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH			
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2215 E. Chase St				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Rep		16b. KIND OF BUSINESS/INDUSTRY Prudential					
17. FATHER'S NAME (First, Middle, Last) Charles F. Dempsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Mae Smith							
19a. INFORMANT'S NAME (Type/Print) Gregory Falcon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3780 Bonview Ave. Balto., MD 21213							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 10/20 Randallstown, MD		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St.							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUBARACHNOID HEMORRHAGE b. RUPTURED BERRY ANEURYSM c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Morton</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCTOBER 16, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCO F. GOMEZ JR MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John S. Anderson</i>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

94 30363

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Caroline W. Knobel Robison				2. DATE OF DEATH MONTH DAY YEAR Oct 14 1994		3. TIME OF DEATH 2:04 P M	
4. SOCIAL SECURITY NUMBER 216-24-3677		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH MONTH DAY YEAR July 19 1904	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Asbury Wilson Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg	
9c. COUNTY OF DEATH Montgomery				10a. STATE MD		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 407 Russell Ave, Apt 601	
10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) College (1-4 or 5+)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stationery/Real Estate		15b. KIND OF BUSINESS/INDUSTRY Sales	
17. FATHER'S NAME (First, Middle, Last) Burkhart M Knobel				16. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia M Wallace			
19a. INFORMANT'S NAME (Type/Print) Clinton M. Robison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 So. 11th St, #2, Phila, Penna 19147			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/15		20c. LOCATION — City or Town, State Catonsville, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dean P Charlton	
22. NAME AND ADDRESS OF FACILITY Charlton Funeral Home 2007 Eastern Ave, Baltimore, MD 21231				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic lymphocytic leukemia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lymphoma				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Steven J. Furem M.D.		29c. LICENSE NUMBER D18186	
29d. DATE SIGNED (Month, Day, Year) 10/14/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Anderson-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Frank E. Sydnor				2. DATE OF DEATH MONTH 10 DAY 11 YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 218-26-4517		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-19-1929	
9a. FACILITY NAME (If not institution, give street and number) 4400 Dunland Avenue Road				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH Va	
10a. STATE Md				10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 4400 Dunland Road			
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) College		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Admiral Sydnor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lizzie Wormley			
19a. INFORMANT'S NAME (Type/Print) Ernest M. Sydnor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Newburn Avenue Balto, Md 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet		20c. DATE 10/18/94		20d. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>chronic obstructive pulmonary disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Chy MD</i>				29c. LICENSE NUMBER D43472		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.


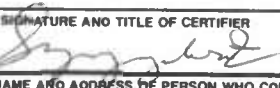
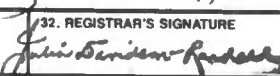
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30365

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRY C. SNYDER				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 3 10A M	
4. SOCIAL SECURITY NUMBER 219-16-9154		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH Month, Day, Year 2/26/25	
9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Pikesville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 730 Cliffedge Road				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Foreman		16b. KIND OF BUSINESS/INDUSTRY Chessie System	
17. FATHER'S NAME (First, Middle, Last) Elmer H. Snyder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Richards			
19a. INFORMANT'S NAME (Type/Print) Mrs. Adelle Snyder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Cliffedge Road Pikesville, MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Mausoleum		DATE 10/14/94		20c. LOCATION — City or Town, State Pikesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Melanotic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40491		29d. DATE SIGNED (Month, Day, Year) 10.12.1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Syed M A Ring NWHC Randallstown 21133							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5872-510

blh

94 30366

ITEMS: 23 PART I, 27 PEP MEO G-717 11/4/94 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernard Anthony Smithmyer, Jr.				2. DATE OF DEATH MONTH DAY YEAR Oct 13 1994		3. TIME OF DEATH M 0509	
4. SOCIAL SECURITY NUMBER 214-68-2241		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 25, 1955	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Pikesville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4212 Lowell Drive				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Systems Analyst S.S.A.		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Bernard A. Smithmyer, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marian Ronan			
19a. INFORMANT'S NAME (Type/Print) Mrs. Marian Smithmyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4212 Lowell Drive Pikesville, MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 10/17/94		20c. LOCATION — City or Town, State Pikesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CIRRHOSIS OF LIVER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XERO/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King M.D.		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) Oct 13 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be sent within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


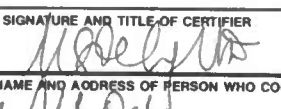
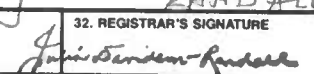
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94-30367

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PEGGY C. SCHARF				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 11:05 P M	
4. SOCIAL SECURITY NUMBER 219-38-1228		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 19, 1939	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9812 Southall Road	
10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 Year College (1-4 or 5+) 1 Year				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Maryland State Highway Admin	
17. FATHER'S NAME (First, Middle, Last) Edward Chell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret McCafferty			
19a. INFORMANT'S NAME (Type/Print) Mr. James W. Scharf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9812 Southall Road Randallstown, MD 21133			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service 10/13/94 Hampstead, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  HOUSE OFFICER				29c. LICENSE NUMBER D-40521		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. Ocharny 5401 OLD COURT ROAD NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD 21133							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

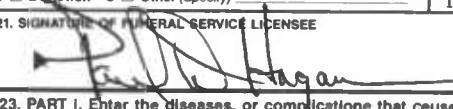
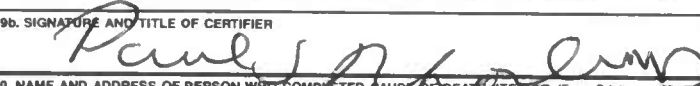
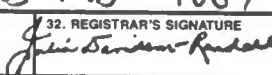
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30368

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sharon Lee Smith				2. DATE OF DEATH MONTH DAY YEAR 10/ 12/ 1994		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 219-40-1078		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 50 YRS.	7. DATE OF BIRTH (Month, Day, Year) 01/18/44	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Pleasant Living Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Edgewater		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Arbutus		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1013 Leeds Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Self			
17. FATHER'S NAME (First, Middle, Last) Robert H. Glensky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Bergan			
19a. INFORMANT'S NAME (Type/Print) Robert Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Leeds Avenue, Arbutus, MD 21227			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/14		20c. LOCATION — City or Town, State Catonsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Metastatic Breast Cancer b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate Interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 022028		29d. DATE SIGNED (Month, Day, Year) 10 12 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul S Rhodes MD 1667 Crofta Center Crofta Md 21114							
31. DATE FILED (Month, Day, Year) OCT 15 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Melvin, Kenny Snyder</u> <u>Melvin Snyder</u> MELVIN K. SNYDER				2. DATE OF DEATH MONTH <u>10</u> DAY <u>12</u> YEAR <u>94</u>		3. TIME OF DEATH <u>1:10</u> <u>4</u> M	
4. SOCIAL SECURITY NUMBER <u>212-38-2100</u>		5. SEX <u>1</u> M <u>2</u> F		6. AGE (In yrs. last birthday) <u>55</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>1939</u> <u>5-02-1939</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Fallston General Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Harford County</u>		9c. COUNTY OF DEATH <u>Harford</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Fallston</u>		10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO	
10e. STREET AND NUMBER <u>3467 Fallston Road</u>				10f. ZIP CODE <u>21047</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <u>1</u> Never Married <u>2</u> <input checked="" type="checkbox"/> Married <u>3</u> Widowed <u>4</u> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u> <u>12</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Carpenter</u>		15b. KIND OF BUSINESS/INDUSTRY <u>Construction</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Melvin William Snyder</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Edith Williams</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Dolores E. Snyder</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3467 Fallston Rd. Fallston, Md. 21047</u>			
20a. METHOD OF DISPOSITION <u>1</u> <input checked="" type="checkbox"/> Burial <u>2</u> <input type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State <u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. Johns Epis. Cem. 10/15/94</u>		DATE <u>10/15/94</u>		20c. LOCATION — City or Town, State <u>Kingsville, Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSER <u>E. F. Lassahn</u>				22. NAME AND ADDRESS OF FACILITY <u>E. F. Lassahn Funeral Home</u> <u>11750 Belair Road Kingsville, Md. 21087</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Aspergillus pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Carcinoma of lung</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Brain metastasis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> <input checked="" type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA OTHER: <u>4</u> <input type="checkbox"/> Nursing Home <u>5</u> <input type="checkbox"/> Residence <u>6</u> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending Investigation <u>2</u> <input type="checkbox"/> Accident <u>6</u> <input type="checkbox"/> Could not be determined <u>3</u> <input type="checkbox"/> Suicide <u>4</u> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <u>1</u> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>IAN D. SOMERVILLE</u>				29c. LICENSE NUMBER <u>D14544</u>		29d. DATE SIGNED (Month, Day, Year) <u>Oct 12, 1994</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>400 LEWIS STREET HAVRE DE GRACE MD 21078</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



x




x

x

22 November 1964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE STARKE			2. DATE OF DEATH MONTH DAY YEAR OCT. 07, 1994		3. TIME OF DEATH 12:13 P M
4. SOCIAL SECURITY NUMBER 217-09-1378	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 4, 1904	8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2405 Ellamont Avenue		10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator		16b. KIND OF BUSINESS/INDUSTRY Revere Copper & Brass Co.	
17. FATHER'S NAME (First, Middle, Last) Mack Starke		18. MOTHER'S NAME (First, Middle, Maiden Surname) Patty Malone			
19a. INFORMANT'S NAME (Type/Print) Gracie Starke		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 North Ellamont Street Baltimore, MD 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park		20c. LOCATION — City or Town, State 10/12 Baltimore Co, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> Inquiry					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) OCT. 07, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30371

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARVEY B. Seay				2. DATE OF DEATH MONTH 10 - DAY 9 - YEAR 94		3. TIME OF DEATH 9:15 A.M.	
4. SOCIAL SECURITY NUMBER 215-05-6513		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-2-09	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Lorien Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Columbia	
9c. COUNTY OF DEATH Howard				10a. STATE Maryland			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 7400 Ripple Road			
10f. ZIP CODE 21244				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) High School		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed		16b. KIND OF BUSINESS/INDUSTRY Dry Cleaner			
17. FATHER'S NAME (First, Middle, Last) Albert Seay				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Greenhill			
19a. INFORMANT'S NAME (Type/Print) Marian S. Christian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7133 Rivers View Court Columbia, MD 21044			
20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 10/14		20c. LOCATION — City or Town, State Baltimore County, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bay L. Folger				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral ventricular accident Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertension c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Seay				29c. LICENSE NUMBER M 78210		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STERNY SEMS ELICUT City, Md.							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

94 30372

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH SURATA				2. DATE OF DEATH MONTH 10 - DAY 16 - YEAR 94		3. TIME OF DEATH 5:02A M	
4. SOCIAL SECURITY NUMBER 217-26-7323		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-14-31	
9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2018 Mosby Ave				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY City Water Dept.			
17. FATHER'S NAME (First, Middle, Last) Michael Surata				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Dubiel			
19a. INFORMANT'S NAME (Type/Print) Shirley Wolf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1867 Loch Shiel Rd. Baltimore, Md 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Rosary Cem		DATE 10-19		20c. LOCATION — City or Town, State Baltimore, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Colt Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Pt Rd 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> a. DUE TO (OR AS A CONSEQUENCE OF): b. UPPER GASTROINTESTINAL BLEED c. DISSEMINATED INTRAVASCULAR COAGULOPATHY d. </div> </div>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R. DEPESTRE MD				29c. LICENSE NUMBER D27157		29d. DATE SIGNED (Month, Day, Year) 10-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. DEPESTRE NORTHWEST HOSPITAL CENTER							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


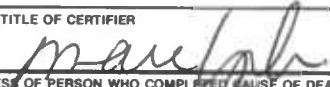

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30373

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET THOMPSON				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1994		3. TIME OF DEATH n/a M	
4. SOCIAL SECURITY NUMBER 219-18-3833		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	7. DATE OF BIRTH (Month, Day, Year) APR. 15, 1924		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 471 LINCOLN DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL CO, MD	
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION GLEN BURNIE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 471 LINCOLN DRIVE				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (0-12) 10 TH College (14 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DIETITARY-COOK		16b. KIND OF BUSINESS/INDUSTRY NURSING HOME			
17. FATHER'S NAME (First, Middle, Last) WILSON R. CAMPBELL				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA WINSMORE			
19a. INFORMANT'S NAME (Type/Print) LESTER THOMPSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 471 LINCOLN DRIVE, GLEN BURNIE, MARYLAND 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CROWNSVILLE VA CEMETERY 10-17		20c. LOCATION — City or Town, State CROWNSVILLE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarct Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST hypertension DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D22110		29d. DATE SIGNED (Month, Day, Year) 10-12-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARC A. KAPH 7845 OAKWOOD RD #300 Glen Burnie MD 21060							
31. DATE FILED (Month, Day, Year) OCT 17 1994 REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 30374

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter R. Turner				2. DATE OF DEATH MONTH DAY YEAR October 14, 1994		3. TIME OF DEATH 6:00 A M	
4. SOCIAL SECURITY NUMBER 216-28-9328		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 19, 1932	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Baltimore		9b. COUNTY OF DEATH	
9c. FACILITY NAME (If not institution, give street and number) 520 S. Smallwood St.				10a. STATE Md.			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 520 S. Smallwood St.			
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouseman		16b. KING OF BUSINESS/INDUSTRY Zamoiski Co.			
17. FATHER'S NAME (First, Middle, Last) Walter M. Turner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie A. Gotti			
19a. INFORMANT'S NAME (Type/Print) Duane K. Turner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 S. Smallwood St., Balto., Md. 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 10/18		20c. LOCATION — City or Town, State Elkridge, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIO PULMONARY ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>METASTATIC CANCER FROM LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>Immediate</u> <u>2 Months</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R Hanan M.D.				29c. LICENSE NUMBER D46227		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAZA HANAN 4660 WILKENS AVE, BALTIMORE MD 21229							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John F. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5877-005
M.L.

94 30375

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS B. TWIST				2. DATE OF DEATH MONTH OCT. DAY 12 YEAR 94		3. TIME OF DEATH 10:52 P M	
4. SOCIAL SECURITY NUMBER 213-52-9667		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 31, 1947	
8. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6906 Wardman Road				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) Executive		16b. KIND OF BUSINESS/INDUSTRY Finance/Banking			
17. FATHER'S NAME (First, Middle, Last) Robert Grey Twist				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verona Fleigh			
19a. INFORMANT'S NAME (Type/Print) H. Parker Twist				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6906 Wardman Road, Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley		20c. LOCATION — City or Town, State 10/15 Lutherville, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John G. Reitz (M-00804)				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute M.D.				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 13, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John J. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30376

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER TERASKIEWICZ				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 7:03 p.m.	
4. SOCIAL SECURITY NUMBER 218-09-5750		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 3, 1920	
8a. FACILITY NAME (If not institution, give street and number) V.A. Med. Ctr. Balto. Md.				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH -	
10a. STATE Maryland		10b. COUNTY -		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2707 Grindon Ave.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II Mer. Seaman		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seaman		15b. KIND OF BUSINESS/INDUSTRY Merchant Marine			
17. FATHER'S NAME (First, Middle, Last) Walter Teraskiewicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Stronkowski			
19a. INFORMANT'S NAME (Type/Print) Mary Stachurski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8908 Kilkenny Circle, Balto. Md. 21236			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) St. Stanislaus Cem. 10/17/94		20c. LOCATION — City or Town, State Balto. Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Raymond A. Weber (Pres.) George A. Weber & Sons Inc.				22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Heart Failure Myocardial infarction Coronary Artery Disease							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael T. Collins				29c. LICENSE NUMBER 04 5237		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael T. Collins 22 S. Greene St. Balto. Md							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3+1

TO THE HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WALTER, TEASKIEWICZ

ITEMS: 23 PART I, 27, 28d, PER MEO FILM G-717 11/23/94 t.t

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ERIKA LAUREN VONG				2. DATE OF DEATH MONTH OCT DAY 12 YEAR 94		3. TIME OF DEATH 6:25 P.M.	
4. SOCIAL SECURITY NUMBER 217-41-5173		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 5		7. DATE OF BIRTH (Month, Day, Year) May 4, 1994	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH Maryland	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9706 Harford Road			
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Chinese Korean	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Timothy Tian Vong				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tiffini Kwon			
19a. INFORMANT'S NAME (Type/Print) Timothy & Tiffini Vong				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9706 Harford Road, Baltimore, Maryland 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 10-14-94 Towson, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. POSITIONAL ASPHYXIA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-11-94		28b. TIME OF INJURY 11:00 P.M.	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT CAUGHT BETWEEN WALL AND BED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9706 Harford Rd Baltimore County, Md	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Benjamin J. Chuteau				29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) OCT 13, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE John Anderson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30378

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CORNELL E VINCENT				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 8 1994		3. TIME OF DEATH HOUR MIN 8:00 A M	
4. SOCIAL SECURITY NUMBER 215-54-6983		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05 03 53	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH -----				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1100 Bolton House Apt. #606				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Edward Burton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Vincent			
19a. INFORMANT'S NAME (Type/Print) Lenora Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Lakewood Street Balto, MD 21205			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/12/94 Balto, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph R. Walters, Jr.</i>				22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Av. Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 12 hours 1 week 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Polydefkis MD Medical Resident</i>				29c. LICENSE NUMBER L5176		29d. DATE SIGNED (Month, Day, Year) 10/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Polydefkis 6000 Wolf St Baltimore MD 21207							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>James M. Smith</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30379.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Tulcia A Wheeler</i>				2. DATE OF DEATH MONTH DAY YEAR <i>October 15 1994</i>		3. TIME OF DEATH <i>0500A</i>	
4. SOCIAL SECURITY NUMBER <i>215-09-6650</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>90</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 9, 1904</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2619 Gwyndale Ave.</i>				10f. ZIP CODE <i>21207</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>11th grade</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Jeremiah Lucey</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Toner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. James Kane</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5902 Hanna Road Sykesville, MD 21784</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery 10/18</i>		20c. LOCATION — City or Town, State <i>Woodlawn, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Corbett</i>				22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Obstructive nephropathy</i> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gastrointestinal bleeding</i> <i>Congestive heart failure</i>						Approximate interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elizabeth M. Burke MD</i>				29c. LICENSE NUMBER <i>D36872</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/15/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Elizabeth M. Burke MD - Randallstown, MD.</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John B. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this license has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked as item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30380

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Helen Weisensel				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 4:45 a.m.	
4. SOCIAL SECURITY NUMBER 220-03-5621		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06/11/01	
9a. FACILITY NAME (If not institution, give street and number) Ridge Way Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cockeysville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 11 Nutmeg-Knoll Ct. Apt. D.			
10f. ZIP CODE 21030				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk		16b. KIND OF BUSINESS/INDUSTRY Department Store	
17. FATHER'S NAME (First, Middle, Last) Michael McCaffery				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary McGrogan			
19a. INFORMANT'S NAME (Type/Print) Margaret C. Disney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Nutmeg-Knoll Ct. Apt. D. Cockeysville, MD 21030			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10/17 Baltimore, MD		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR D. Approximate Interval Between Onset and Death 10 yrs Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CONGESTIVE HEART FAILURE Approximate Interval Between Onset and Death 1 wk							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Norman R. Kleiman MD				29c. LICENSE NUMBER MD D09019		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Norman R. Kleiman, M.D. 3803 Edmundson Avenue Baltimore, MD 21229							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE John D. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30381

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIE B. WILLIAMS				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1994		3. TIME OF DEATH n/a	
4. SOCIAL SECURITY NUMBER 212-36-5934		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 22, 1914	
8. BIRTHPLACE (State or Foreign Country) S. Carolina				9a. FACILITY NAME (If not institution, give street and number) HARFORD GARDENS NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 633 N. AISQUITH STREET APT. 9G	
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) N/A			
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC				16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) PRESTON MOODY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MOLLY JOHNSON			
19a. INFORMANT'S NAME (Type/Print) LILLIE L. LEWIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 LAURETTA AVE./BALTIMORE. MD 21223			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK 10-15			
20c. LOCATION — City or Town, State ARBUTUS, MARYLAND				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jessie L. Chapman</i>			
22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cardiomyopathy			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederic S. Sirkis M.D.</i>				29c. LICENSE NUMBER D22645			
29d. DATE SIGNED (Month, Day, Year) 10/13/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDERIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO MD 21222			
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30382

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sammie Lee Watson				2. DATE OF DEATH MONTH 10 DAY 5 YEAR 94		3. TIME OF DEATH 2:10 AM M	
4. SOCIAL SECURITY NUMBER 259-32-1954		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/18/31	
9a. FACILITY NAME (If not institution, give street and number) VAMC FORT HOWARD				9b. CITY, TOWN OR LOCATION OF DEATH 9600 N. POINT RD.		9c. COUNTY OF DEATH	
10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION 1106 N. PORT ST.	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1106 NORTH PORT STREET			
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 8-14-53-1-28-58		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: A		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) N/A				18. MOTHER'S NAME (First, Middle, Maiden Surname) N/A			
19a. INFORMANT'S NAME (Type/Print) MARGARET THORNTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9600 N. POINT RD.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) CROWNSVILLE		DATE 10-18		20c. LOCATION — City or Town, State SUNRISE BEACH RD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Irvin Carroll</i>				22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL F/A 1712 W. NORTH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Of Lung DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Lopez MD</i>				29c. LICENSE NUMBER D 15232		29d. DATE SIGNED (Month, Day, Year) 10/5/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Raoul-Ivan Lopez, MD, 9600 North Point Road, Fort Howard, Maryland 21052							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30383

Item # 1 File # G 716 10-17-94 N.A. Per Funeral Home

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN S. WHITHERSPOON		2. DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1994		3. TIME OF DEATH 6:30 P M	
4. SOCIAL SECURITY NUMBER 212-86-6093		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.	
7. DATE OF BIRTH (Month, Day, Year) MAY 5, 1967		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3921 Greenmount Avenue		10f. ZIP CODE 21218	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) John Witherspoon		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Helen Southers			
19a. INFORMANT'S NAME (Type/Print) Patrice Witherspoon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Winston Ave. Apt. 12/Baltimore, MD 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park		20c. LOCATION — City or Town, State Randallstown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See Holland</i>		22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VIRAL ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF): b. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death 2 weeks 8 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Polydefkis MD Medical Resident</i>		29c. LICENSE NUMBER LS176		29d. DATE SIGNED (Month, Day, Year) 10/14/1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL POLYDEFKIS, 600 N. WOLF ST BALTIMORE MD 21287.					
31. DATE FILED (Month, Day, Year) 10/14/1994					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

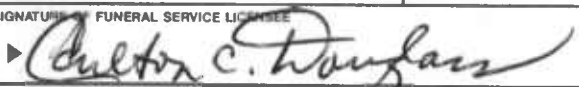
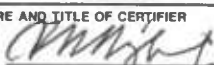
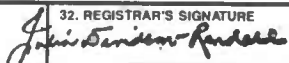
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30384

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT WOODS				2. DATE OF DEATH MONTH DAY YEAR October 10 - 1994		3. TIME OF DEATH 7:21 A.M.	
4. SOCIAL SECURITY NUMBER 215 24 04 84		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-2-1929	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 604 Cator Ave.				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		15b. KIND OF BUSINESS/INDUSTRY Seafood			
17. FATHER'S NAME (First, Middle, Last) Walter Woods				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Lee Lincoln			
19a. INFORMANT'S NAME (Type/Print) Kenneth Woods				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Pleasant Oak Rd. Towson, Md. 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 10-17 Balto. Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Douglass Funeral Service 1701 McCulloh St.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated Intravascular Coagulation DUE TO (OR AS A CONSEQUENCE OF): b. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER, SEVERE DEHYDRATION							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD					
29c. LICENSE NUMBER P-1169		29d. DATE SIGNED (Month, Day, Year) 10/9/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIRGILIO M. AGUILAR, JR. GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30385

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>MOK. C. WONG</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>14</i> YEAR <i>94</i>		3. TIME OF DEATH <i>12.05</i> M			
4. SOCIAL SECURITY NUMBER <i>219 94 5160</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>83</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>01/13/11</i>			
9a. FACILITY NAME (If not Institution, give street and number) <i>Harbor Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore MD, 21225</i>		9c. COUNTY OF DEATH <i>Baltimore City</i>			
10a. STATE <i>Md.</i>		10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>798 Sunnyfield Lane Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>798 Sunnyfield Lane</i>				10f. ZIP CODE <i>21225</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Asian</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>proprietor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>produce business</i>					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
19a. INFORMANT'S NAME (Type/Print) <i>Po Wa Wong</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>(same as 10E)</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holy Cross Cemetery</i>		20c. LOCATION — City or Town, State <i>Baltimore Md. 21225</i>		20d. DATE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY <i>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular accident (infarction)</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Hypertension</i> b. <i>Atrial Fibrillation</i> c. d. Approximate Interval Between Onset and Death <i>94 h.</i> <i>2-3 yrs</i> <i>2-3 yrs</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>House Staff</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>10.14.94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. NAJAM FIROZ Harbor Hospital Center 3001, S. Hanover St. Baltimore MD 21225</i>									
31. DATE FILED (Month, Day, Year) <i>10/14/94 OCT 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John J. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30386

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGIL O. WEBB, Sr				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 1:15 - A.M.	
4. SOCIAL SECURITY NUMBER 220-05-7719		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/10/16	
9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1537 N. BENTALOU ST				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel	
17. FATHER'S NAME (First, Middle, Last) Robert Webb				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bowser			
19a. INFORMANT'S NAME (Type/Print) Lillian Webb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1537 N. Bentalou St Balto, Md 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem Park 10/12/94		20c. LOCATION — City or Town, State Arbutus, Md		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Ebron				22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave Balto, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Aspiration Pneumonia							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Multiple CVA							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Gallegos MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Gallegos MD 22 S. Green St. Balto, Md							
31. DATE FILED (Month, Day, Year) OCT 15 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATION BOARD

STATION BOARD

3

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94 30387

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAUL WALKER				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 107 P.M.	
4. SOCIAL SECURITY NUMBER 232-54-0488		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-1-36	
9a. FACILITY NAME (If not institution, give street and number) HOWARD CO. GENERAL HOSP.				9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		9c. COUNTY OF DEATH HOWARD	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION FULTON		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12397 LIMEKILN RD.				10f. ZIP CODE 21759		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF		15b. KIND OF BUSINESS/INDUSTRY ELEC.			
17. FATHER'S NAME (First, Middle, Last) MELVIN DEXTER WALKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) HALLIE MARIE KEDSOME			
19a. INFORMANT'S NAME (Type/Print) DAVID WALKER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8676 FELSZIEW DR. LAUREL MD. 20723			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRODDY-CHATELAIN 8-14-94		20c. LOCATION — City or Town, State WALTON W. VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Skarda</i>				22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2829 HUDSON ST.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Atherosclerotic Cardiovascular Disease					Approximate Interval Between Onset and Death Years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Hypertension					Yrs
		c. Non Insulin Dependent Diabetes Mellitus					Yrs
		d. Obesity					Yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> ED/ICU OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patricia A. Tore, MD</i>		29c. LICENSE NUMBER D31473		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) PATRICIA A. TORE, MD 4565 ITEM WALKER CONE WAY ELICOTT CITY, MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994		32. REGISTRAR'S SIGNATURE <i>John J. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30388

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John H. Wiedeck				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 1994		3. TIME OF DEATH 10 AM	
4. SOCIAL SECURITY NUMBER 213-01-0594		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/9/06	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME-CROMWELL				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8512 HARRIS AVE.				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELEVATOR OPERATOR		16b. KIND OF BUSINESS/INDUSTRY CROWN, CORK & SEAL			
17. FATHER'S NAME (First, Middle, Last) FREDERICK WIEDECK				18. MOTHER'S NAME (First, Middle, Maiden Surname) REGINA GUTTENBERGER			
19a. INFORMANT'S NAME (Type/Print) MARY A. WIEDECK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8512 HARRIS AVE. BALTIMORE, MD. 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY REDEEMER CEMETERY 10/15/94 BALTIMORE, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME 7401 BELAIR ROAD BALTIMORE, MD. 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 2 weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression Dementia						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederic S. Sirkis M.D.</i>				29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDERIC S. Sirkis M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222							
31. DATE FILED (Month, Day, Year) OCT 17 1994 REGISTRAR'S SIGNATURE <i>John Shuster-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

602

11-20-1919. 10:00 AM

94 30389

Item 2, g-716, 10-21-94, per MD., dr

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RAYMOND E. WARTHEN				2. DATE OF DEATH MONTH OCTOBER DAY 15 YEAR 1994		3. TIME OF DEATH 4:45 P M	
4. SOCIAL SECURITY NUMBER 220149845		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/10/25	
9a. FACILITY NAME (If not institution, give street and number) PARKVILLE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE		9c. COUNTY OF DEATH MARYLAND	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8021 EDGEWATER AVE				10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ==		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STEEL WORKER		16b. KIND OF BUSINESS/INDUSTRY EASTERN STAINLESS			
17. FATHER'S NAME (First, Middle, Last) RAYMOND WARTHEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN REXROTH			
19a. INFORMANT'S NAME (Type/Print) DOROTHY J. WARTHEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8021 EDGEWATER AVE ROSEDALE, MD 21237			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLLY HILLS		20c. LOCATION — City or Town, State 10/18 BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cigarette Smoking Coronary artery Disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER D. Weiner MD				29c. LICENSE NUMBER D26475		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. G. WEINER 9512 Herford Rd.							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

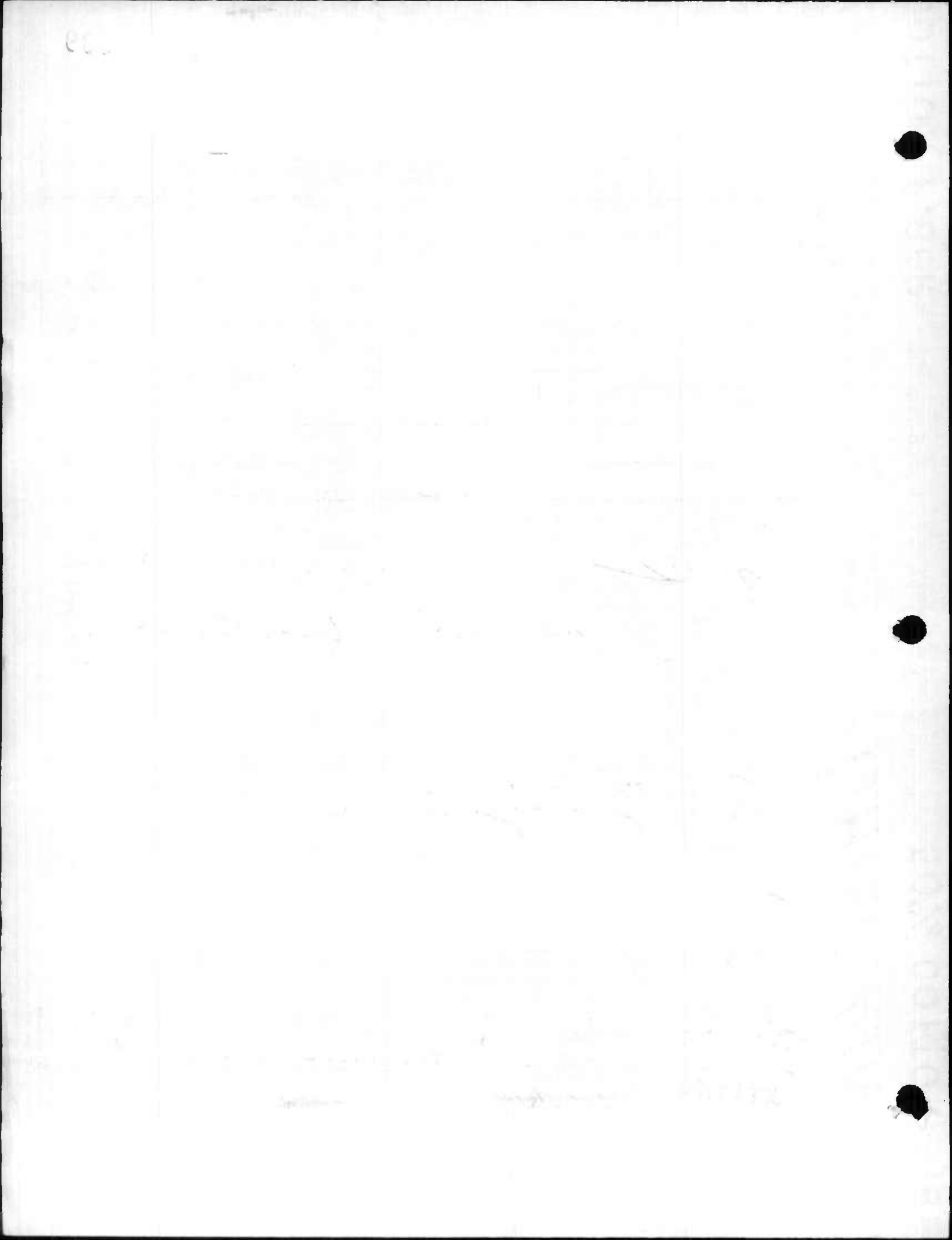
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

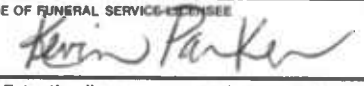

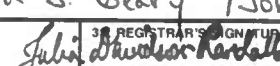
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10+1



94 30390

Item # 1,19b File # G 716 10-17-94 W.A. Pre Funeral Home
 1. STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BOOKER Taylor WASHINGTON		2. DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1994		3. TIME OF DEATH 12:49 p M	
4. SOCIAL SECURITY NUMBER 249-34-2653		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Nov 11, 1925		8. BIRTHPLACE (State or Foreign Country) South Carolina		9. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL	
10. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 921 Abbott Court		10f. ZIP CODE 21202	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) Social Security Admin	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U. S. Government		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) Vander Washington	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Isaac		19a. INFORMANT'S NAME (Type/Print) Euzonia Washington		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Abbott Court Baltimore, Maryland 21203	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hills Memorial Park 10/15 Chase, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE EMPLOYEE 		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Multisystem Failure DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 weeks 3 weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status epilepticus		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 	
29c. LICENSE NUMBER Z3886		29d. DATE SIGNED (Month, Day, Year) 10/11/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard D. Geary / Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD	
31. DATE FILED (Month, Day, Year) OCT 17, 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30391

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LORRAINE S. YOMMER				2. DATE OF DEATH MONTH DAY YEAR October 15, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 213 24 6105		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/28/1928	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Garret	
10c. CITY, TOWN OR LOCATION Swanton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt. 2 Box 194 B	
10f. ZIP CODE 21561				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter				16b. KIND OF BUSINESS/INDUSTRY Baltimore County School Board			
17. FATHER'S NAME (First, Middle, Last) William A. Yommer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Hazel Butler			
19a. INFORMANT'S NAME (Type/Print) Jacqueline Yommer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt.2 Box 194 B Swanton, Maryland 21561			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens 10/18/94 Balto. Co., Md.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY BRUZZDZINSKI FUNERAL HOME P.A. 1407 Eastern Ave Baltimore, Maryland 21221				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Terminal congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Endstage coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 8 hours 1 week 1 year			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Surgeon				29c. LICENSE NUMBER D45022		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sinai Hospital, Baltimore, MD							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30392

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry John Young Sr.				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 212-03-4972		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-21-1912	
9a. FACILITY NAME (If not institution, give street and number) 1227 Newfield Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH Md.	
10a. STATE Md.				10b. COUNTY Balto.		10c. CITY, TOWN OR LOCATION 21207	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1227 Newfield Rd.			
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Foreman		16b. KIND OF BUSINESS/INDUSTRY City of Baltimore			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Skelton			
19a. INFORMANT'S NAME (Type/Print) Carol A. Benvenuti				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1227 Newfield Rd. Balto., Md. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. 10-18-94		20c. LOCATION — City or Town, State Balto., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure COOPD						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. DATE SIGNED (Month, Day, Year) 10/16/94			
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas J. Lynch MD				29c. LICENSE NUMBER P42196			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas J. Lynch 301 St. Paul Balto MD 21202							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



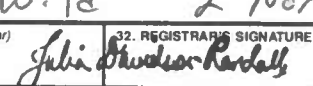
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30393

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emma Virginia Zimmerman				2. DATE OF DEATH MONTH DAY YEAR October 12, 1994				3. TIME OF DEATH 2:00 P M	
4. SOCIAL SECURITY NUMBER 213-20-2695		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 30, 1913		8. BIRTHPLACE (State or Foreign Country) Balto. Md.	
9a. FACILITY NAME (If not institution, give street and number) 4970 Jolly Acres Rd. (Sunshine Acres) White Hall				9b. CITY, TOWN OR LOCATION OF DEATH White Hall				9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION White Hall				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4970 Jolly Acres Rd. (Sunshine Acres)				10f. ZIP CODE 21161		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Homemaker	
17. FATHER'S NAME (First, Middle, Last) Earl Dinsmore Calligan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Louise Arnold					
19a. INFORMANT'S NAME (Type/Print) Ronald Zimmerman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 North Charles St. Unit #503 Baltimore, Md. 21218					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 10/15/94				20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 6 mth	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Dementia								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Boarding Home							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 435522		29d. DATE SIGNED (Month, Day, Year) 10-13-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Wild 2 North Ave Bel Air Md 21014									
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


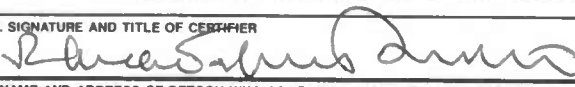

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30394

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOU ALICE ALEXANDER				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 15 1994		3. TIME OF DEATH 1:20a M	
4. SOCIAL SECURITY NUMBER 214-22-2230		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1913	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 301 McMechen Street Apt. 924	
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeping		16b. KIND OF BUSINESS/INDUSTRY Mt. Calvary E.P. Church	
17. FATHER'S NAME (First, Middle, Last) Robert Alexander				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Simons			
19a. INFORMANT'S NAME (Type/Print) Lucille Hill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 Francis Street/Baltimore, MD 21217			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery		DATE 10-18		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEVERE ANEMIA DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 day 1989							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29071		29d. DATE SIGNED (Month, Day, Year) 10-17-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAVI ANANDAKRISHNAN, M.D. 821 N. EUTAW ST #305 BALTIMORE 212							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30395

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHERINE BOYLE Katherine Lacy H. Boyle				2. DATE OF DEATH MONTH DAY YEAR 10-09-1994		3. TIME OF DEATH 6:27p.m.	
4. SOCIAL SECURITY NUMBER 212 20 4567		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 07-27-1923	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Pickers Gill 615 Chestnut Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore County				10a. STATE MD		10b. COUNTY Baltimore Co	
10c. CITY, TOWN OR LOCATION TOWSON				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER Pickersgill 615 Chestnut Ave.	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John Robert Harman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Butterfield			
19a. INFORMANT'S NAME (Type/Print) F. Bernard Boyle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Chestnut Ave. Towson, MD 21204			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of uncertain origin Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. H/O Laryngeal Cancer H/O Tongue Cancer Smoking - Cigarettes							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER G. A. Riley G. A. Riley				29c. LICENSE NUMBER 025205		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. A. Riley G. A. Riley							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE Ar. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30396

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Daniel Brice				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH 2:30 P M	
4. SOCIAL SECURITY NUMBER 212-34- 9644		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) % 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-24-37	
9a. FACILITY NAME (If not Institution, give street and number) 1405 W. Mosher St.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH MD.	
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2028 E. Biddle St.				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laboreff		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Henry Brice				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Brice			
19a. INFORMANT'S NAME (Type/Print) Melvorn C. Brice				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2028 E. Biddle St. Baltimore, MD. 21213			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem. Park 10-21-94 Baltimore, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H PA 638 N. Gilmor St. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. myocardial infarct DUE TO (OR AS A CONSEQUENCE OF): hypertension DUE TO (OR AS A CONSEQUENCE OF): arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA P. vascular disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER H. A. Brice Private Physician		29c. LICENSE NUMBER 213248		29d. DATE SIGNED (Month, Day, Year) 10/17/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASIA L. Smith, 5000 Goldfrank road, Baltimore, MD 21229.							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2



94 30397

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary L. Bonnett				2. DATE OF DEATH MONTH DAY YEAR October 17 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 213-32-0073		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 4, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3409 Roselawn Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, City	
9c. COUNTY OF DEATH Maryland				10a. STATE Maryland		10b. COUNTY Baltimore, City	
10c. CITY, TOWN OR LOCATION Baltimore, City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 3409 Roselawn Ave.	
10f. ZIP CODE 21214				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Salvatore Salerno				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Marianna			
19a. INFORMANT'S NAME (Type/Print) Cynthia Ciarpella				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 South Potomac Street 21224			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Mausoleum 10/19/94		20c. LOCATION — City or Town, State Balto. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Ziegner				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. Baltimore, Maryland 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Advanced Age b. Due to (OR AS A CONSEQUENCE OF): c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Disorder							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER R. Liberto, M.D.		29c. LICENSE NUMBER 201468		29d. DATE SIGNED (Month, Day, Year) 10-17-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Liberto M.D. 3508 Bank Street - 21224	
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE John S. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020


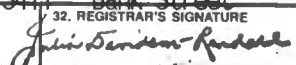
TO THE HOSPITAL OPERATING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30398

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Stephen F. Brunek				2. DATE OF DEATH MONTH DAY YEAR October 16 1994		3. TIME OF DEATH 12:30 P. M.	
4. SOCIAL SECURITY NUMBER 217-03-0680		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 10, 1908	
9a. FACILITY NAME (If not Institution, give street and number) 110 Manor Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, City		9c. COUNTY OF DEATH	
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore, City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2219 Clowville Ave.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Milkman		15b. KIND OF BUSINESS/INDUSTRY Dairy			
17. FATHER'S NAME (First, Middle, Last) Steven F. Brunek				16. MOTHER'S NAME (First, Middle, Maiden Surname) Dobra Vodsky			
19a. INFORMANT'S NAME (Type/Print) Lois R. Leicht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Manor Ave. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens Of Faith 10-20		20c. LOCATION — City or Town, State Balto. Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death SAME
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION ALZHEIMERS							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER David Silver M.D.				29c. LICENSE NUMBER #43234		29d. DATE SIGNED (Month, Day, Year) OCTOBER 17, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Silver M.D. 3411 Bank Street 21224							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30399

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen S. Bostock</i>			2. DATE OF DEATH MONTH DAY YEAR <i>Oct. 13 1994</i>		3. TIME OF DEATH <i>10:55 A.M.</i>
4. SOCIAL SECURITY NUMBER <i>167-50-2383</i>	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>91</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>June 12, 1903</i>	8. BIRTHPLACE (State or Foreign Country) <i>Mass.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>306 Northfield Place</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE <i>Md.</i>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>306 Northfield Place</i>		10f. ZIP CODE <i>21210</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (14 or 5+) <i>2</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Steven Maloney</i>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary DeLori</i>		
19a. INFORMANT'S NAME (Type/Print) <i>Barbara Bell, M.D.</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>306 Northfield Place Baltimore, Md. 21210</i>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Patrick Cath. Cemetery 10-17-94 Carlisle, Pa.</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. Brian Powell</i>			22. NAME AND ADDRESS OF FACILITY <i>11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136</i>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Brain tumor & respiratory arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate interval Between Onset and Death <i>3 wks.</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara Bell M.D.</i>		29c. LICENSE NUMBER <i>DO 6475</i>		29d. DATE SIGNED (Month, Day, Year) <i>10-13-1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>306 Northfield Pl. Balt. Md. 21210 DR. BARBARA BELL</i>					
31. DATE FILED (Month, Day, Year) <i>OCT 18 1994</i>		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30400

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM		BLUEFORD		2. DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1994		3. TIME OF DEATH 10:30	
4. SOCIAL SECURITY NUMBER 219-03-2411		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1920	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A			
9b. FACILITY NAME (If not institution, give street and number) 526 N. MONTFORD AVENUE				RESIDENCE OF DECEDENT			
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 526 N. Montford Avenue				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Preston Blueford		18. MOTHER'S NAME (First, Middle, Maiden Surname) Gracie					
19a. INFORMANT'S NAME (Type/Print) William Beauford		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 Marbourne Avenue/Baltimore, MD 21230					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Zion Cemetery		DATE 10/18		20c. LOCATION — City or Town, State Lansdowne, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lee V. Holland</i>		22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): b. Cardiomyopathy C CHF DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Nonfunctional Gastrointestinal ② Chronic Liver ③ Hypertension							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i> MD		29c. LICENSE NUMBER DB2975		29d. DATE SIGNED (Month, Day, Year) 10-14-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. K. RAMAIAH M.D. 447 N. KENWOOD AVE BALTO							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30401

ITEM: 1. PER F.H. FILM G-716 10/18/94 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Johnny Paul Byrd SR.</u>				2. DATE OF DEATH MONTH DAY YEAR <u>10-12-94</u>		3. TIME OF DEATH <u>3:15 P M</u>	
4. SOCIAL SECURITY NUMBER <u>215-24-9257</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>65</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11-22-28</u>	
8. BIRTHPLACE (State or Foreign Country) <u>S. CAROLINA</u>				9a. FACILITY NAME (If not institution, give street and number) <u>5206 Craig Avenue</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>n/a</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>n/a</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>5206 Craig Avenue</u>	
10f. ZIP CODE <u>21212</u>				10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 TH</u> College (1-4 or 5+) <u>-</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>POSTAL CLERK</u>		16b. KIND OF BUSINESS/INDUSTRY <u>US POST OFFICE</u>			
17. FATHER'S NAME (First, Middle, Last) <u>ROOSEVELT D. BYRD</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>GERTRUDE MILLER</u>			
19a. INFORMANT'S NAME (Type/Print) <u>SEDONIA BYRD</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5206 CRAIG AVENUE, BALTIMORE, MARYLAND # 12</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARRISON FOREST VA CEMETERY</u>		20c. LOCATION — City or Town, State <u>10-19 OWINGS MILLS, MD</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <u>WM.C.MARCH FH.-1101 E. NORTH AVENUE</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Adnocarcinoma to Bone</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <u>015450</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/12/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Mohamed Al-Ibrahim, M.D., 10 N. Greene St., Baltimore, MD 21201</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 18 1994</u>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.


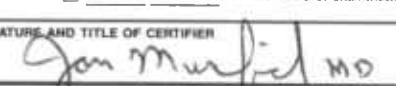
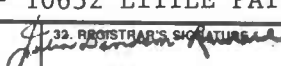
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30402

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET A. BROWN				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 17, 1994				3. TIME OF DEATH 2:30 AM		
4. SOCIAL SECURITY NUMBER 213-10-6595		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7. DATE OF BIRTH (Month, Day, Year) FEB. 26, 1914				8. BIRTHPLACE (State or Foreign Country) MARYLAND						
9a. FACILITY NAME (If not Institution, give street and number) 11901 TRIDELPHIA ROAD				9b. CITY, TOWN OR LOCATION OF DEATH ELLICOTT CITY				9c. COUNTY OF DEATH HOWARD		
10a. STATE MARYLAND			10b. COUNTY HOWARD			10c. CITY, TOWN OR LOCATION ELLICOTT CITY			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11901 TRIDELPHIA ROAD						10f. ZIP CODE 21042		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8th GRADE College (1-4 or 5+) 			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINE OPERATOR			16b. KIND OF BUSINESS/INDUSTRY J.E. SMITH BOX CO.				
17. FATHER'S NAME (First, Middle, Last) JAMES WHEELER				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE SEIFERT						
19a. INFORMANT'S NAME (Type/Print) JANICE SENN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11901 TRIDELPHIA ROAD - ELLICOTT CITY, MD. 21042						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CRESTLAWN CEMETERY		DATE 10/19		20c. LOCATION — City or Town, State MARRIOTTSTVILLE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic brain Cancer DUE TO (OR AS A CONSEQUENCE OF): c. Colonic Adenocarcinoma DUE TO (OR AS A CONSEQUENCE OF): d. 									Approximate Interval Between Onset and Death 6 months 4 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic anemia, SIP RT to chest/head.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 030573		29d. DATE SIGNED (Month, Day, Year) 10-17-94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) DR. JON MINFORD - 10632 LITTLE PATUXENT PARKWAY - COLUMBIA, MD. 21044										
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 24a is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30403

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Phillip T. Candeloro</u>				2. DATE OF DEATH MONTH DAY YEAR <u>10/16/94</u>		3. TIME OF DEATH <u>M</u>	
4. SOCIAL SECURITY NUMBER <u>212-03-9349</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>75</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>07/10/19</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes CPER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>Baltimore</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>5041 Frederick Avenue</u>				10f. ZIP CODE <u>21229</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW2</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0-8th</u> College (1-4 or 5+) <u>plumber</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>plumber</u>		16b. KIND OF BUSINESS/INDUSTRY <u>construction</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Serafino Candeloro</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Besisi</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Isbella Candeloro</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5041 Frederick Ave. Baltimore, Md. 21229</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Maryland Veterans Cem. 10/20/94</u>		20c. LOCATION — City or Town, State <u>Crownsville, Maryland</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <u>Ambrose Funeral Home, Inc.</u> <u>1328 Sulphur Spring Road 21227</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Cardiopulmonary arrest</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Arteriosclerotic Heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate interval Between Onset and Death <u>Immediate</u> <u>Years</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Congestive cardiomyopathy, cardiac dysrhythmias,</u> <u>Hyperlipoproteinemia, Valvular Heart Disease</u> <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <u>Dr. Jorge Secada</u>				29c. LICENSE NUMBER <u>D22633</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/18/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dr. Jorge Secada 7401 Osler Drive Towson, Maryland 21204 Suite #204</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 18 1994</u>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

94 30404

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA W. CRONIN				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 215-10-1696		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 7, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Longview Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Manchester	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Manchester				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3215 Boone Drive	
10f. ZIP CODE 21102				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Balto. Co. Board of Educ.	
17. FATHER'S NAME (First, Middle, Last) Fred Wright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Greene			
19a. INFORMANT'S NAME (Type/Print) Gretchen F. Hyneckal				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 Boone Drive Manchester, Md. 21102			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation 10-19-94		20c. LOCATION — City or Town, State Hampstead, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE E. Brian Powell				22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Resp. Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Chronic obstructive pulmonary Disease c. d.						Approximate Interval Between Onset and Death 2 days 3 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Corrupted Stenosis Rt. Hypothyroidism						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W H Foard MD				29c. LICENSE NUMBER 1202386		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W H Foard MD 3223 MAIN ST. MANCHESTER, MD 21102							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Howard Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

LIBRARY

1911

CHICAGO, ILL.

94 30405

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REVA CYTRYN				2. DATE OF DEATH MONTH DAY YEAR October 15 1994		3. TIME OF DEATH 2:30 P.M.	
4. SOCIAL SECURITY NUMBER 213-36-3474		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04/20/12	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3601 CLARKS LANE APT. 111				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) accountant		16b. KIND OF BUSINESS/INDUSTRY ACCOUNTING			
17. FATHER'S NAME (First, Middle, Last) SOLOMON GLIKSMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) CHAYA LEWIN			
19a. INFORMANT'S NAME (Type/Print) DR. LEON CYTRYN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9513 MIDWOOD RD. SILVER SPRING, MD. (20910)			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. OF OLIVES 10/16		20c. LOCATION — City or Town, State JERUSALEM, ISRAEL			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multi-organ dysfunction DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Sepsis Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. Liver lesions DUE TO (OR AS A CONSEQUENCE OF): d. Pneumonia							Approximate Interval Between Onset and Death 1 week 3 wks Unknown 3 wks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert E. Davis, MD				29c. LICENSE NUMBER AS 2102321 RD 9776		29d. DATE SIGNED (Month, Day, Year) October 15, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30406

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE COHEN				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 1994		3. TIME OF DEATH 2:05P M	
4. SOCIAL SECURITY NUMBER 216-01-4067		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-02-1902	
9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN		9c. COUNTY OF DEATH BALTIMORE			
10a. STATE MD				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 7019 WALLIS AVENUE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY SARATOGA SUPPLY			
17. FATHER'S NAME (First, Middle, Last) AARON COHEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH GERBER			
19a. INFORMANT'S NAME (Type/Print) DR. BURTON POGELL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9214 ISPAHAN LOOP, LAUREL, MD 20708			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MIKRO KODESH BETH ISRAEL 10-16-94 BALTIMORE, MD		20c. LOCATION — City or Town, State BALTIMORE, MD		20d. DATE 10-16-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Andrew L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Dementia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Mishkin MD</i>				29c. LICENSE NUMBER 024266		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4000 Old Court Rd, Balto. MD 21208 David Mishkin MD							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30407

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RHODA S COLEMAN				2. DATE OF DEATH OCT. 14, 1994		3. TIME OF DEATH 6:45 A M	
4. SOCIAL SECURITY NUMBER 218-26-9333		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/20/1930	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3601 CLARKS LA., APT. 410				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY FOOD			
17. FATHER'S NAME (First, Middle, Last) ABRAHAM ISADORE COLEMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA BERKOWICH			
19a. INFORMANT'S NAME (Type/Print) CHARLOTTE LAKEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 CLARKS LA., APT. 516 BALTO., MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TELLOH 10/16/94		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Cottle</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>emphysema</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypoxic brain injury</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gay Hoffman MD</i>				29c. LICENSE NUMBER D25001		29d. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAY LIPPMAN MD 10085 Red Run Blvd OWINGS MILLS MD 21117							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John Swanson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 30408

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sue M. Caporossi				2. DATE OF DEATH MONTH Oct. DAY 13 YEAR 1994		3. TIME OF DEATH 3:00am M	
4. SOCIAL SECURITY NUMBER 218-32-5671		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 11, 1917	
9a. FACILITY NAME (If not institution, give street and number) 921 Woodlyn Road				9b. CITY, TOWN OR LOCATION OF DEATH Essex		9c. COUNTY OF DEATH West Virginia	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 921 Woodlyn Road				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Richard Bilbie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marinda Lusk			
19a. INFORMANT'S NAME (Type/Print) James M. Caporossi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Homberg Ave. Baltimore Md. 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10/17/94		20c. LOCATION — City or Town, State Baltimore MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute intracerebral hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan O'Donovan, M.D.				29c. LICENSE NUMBER D07632		29d. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan O'Donovan, M.D. 2112 DUNDALK AVE BALTO MD							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE J. J. [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked as item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30409

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA KNIGHTS CAMPBELL				2. DATE OF DEATH 10-11-94 MONTH DAY YEAR		3. TIME OF DEATH 10:55 A M	
4. SOCIAL SECURITY NUMBER 094 01 4222		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH 1-10-1916 (Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number) Atlantic General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Berlin		9c. COUNTY OF DEATH Worcester County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Worcester County		10c. CITY, TOWN OR LOCATION Berlin		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2882 OceanPines 5 Whaler Lane				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Homemaker	
17. FATHER'S NAME (First, Middle, Last) Miles Standish Bromley Knights				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Knights Hammond			
19a. INFORMANT'S NAME (Type/Print) Jack Campbell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21811 2882 Ocean Pines, 5 Whaler Lane, Berlin, MD			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>intr. cerebral bleed</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 12 hours 20 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> physician				29c. LICENSE NUMBER H44283		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert D. ... 9733 Herith ... Drive Berlin MD 21811							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

EX-111-1111

94 30410

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MYRTLE T. DAILEY				2. DATE OF DEATH MONTH OCTOBER DAY 14, YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 215-07-6934 A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 28, 1904	
9a. FACILITY NAME (If not institution, give street and number) 207 HAWTHORNE ROAD				9b. CITY, TOWN OR LOCATION OF DEATH LINTHICUM		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION LINTHICUM		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 207 HAWTHORNE ROAD				10f. ZIP CODE 21091		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY HOMEMAKING			
17. FATHER'S NAME (First, Middle, Last) WILLIAM THORNE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA			
19a. INFORMANT'S NAME (Type/Print) MR. DENNIS MITCHELL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 WASHINGTON BLVD - BALTIMORE, MD 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 10/19		20c. LOCATION — City or Town, State BALTIMORE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>OSTEO POROSIS</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D17753		29d. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K.S. DIMARASOVA - 710 Church St. BALTIMORE, MD. 21225							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5876-510

B.K.S

94 30411

ITEMS: 23 PART I, II, 27, PER MEO FILM 6-717 11/15/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DENETTE DEETS				2. DATE OF DEATH MONTH DAY YEAR OCT. 12 94		3. TIME OF DEATH 1836 P M	
4. SOCIAL SECURITY NUMBER 213-84-7056		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-26-63	
8. BIRTHPLACE (State or Foreign Country) Md.				9. COUNTY OF DEATH N/A			
10. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				11. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			
12. RESIDENCE OF DECEDENT				13. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
14. STATE Md.		15. COUNTY N/A		16. CITY, TOWN OR LOCATION Baltimore		17. ZIP CODE 21223	
18. STREET AND NUMBER 1912 Christian Street-Baltimore, Md.				19. CITIZEN OF WHAT COUNTRY? U. S. A.		20. KIND OF BUSINESS/INDUSTRY N/A	
21. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES N/A		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: white	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		27. KIND OF BUSINESS/INDUSTRY N/A			
28. FATHER'S NAME (First, Middle, Last) Donald White, Jr.				29. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia L. Verill			
30. INFORMANT'S NAME (Type/Print) Donald E. White, Jr.				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 West Meadow Road-Baltimore, Md. 21225			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 10-17-94		34. LOCATION — City or Town, State Baltimore, Md.			
35. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab		36. NAME AND ADDRESS OF FACILITY 3512 Frederick Avenue Baltimore, Md. 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUBARACHNOID HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. RUPTURED BERRY ANEURYSMS (2) DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COCAINE USE, PREGNANCY INDUCED HYPERTENSION							
24. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
26. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>		27. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
28. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		29. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		30. DATE OF INJURY (Month, Day, Year)		31. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		33. DESCRIBE HOW INJURY OCCURRED					
34. LOCATION (Street and Number or Rural Route Number, City or Town, State)		35. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
36. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King		37. LICENSE NUMBER O.C.M.E		38. DATE SIGNED (Month, Day, Year) OCT. 14, 1994			
39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201							
40. DATE FILED (Month, Day, Year) OCT 18 1994		41. REGISTRAR'S SIGNATURE John Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

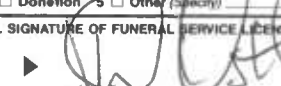
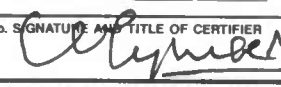
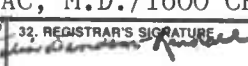
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30412

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORIS E LIZABETH DAVIS				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 06:40 PM	
4. SOCIAL SECURITY NUMBER 218-22-8090		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-13-1927	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION LOCHEARN				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3720 OAK AVENUE	
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GS-11-RECLAIMOR		16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY ADMINISTRATION	
17. FATHER'S NAME (First, Middle, Last) GEORGE H. DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE A. SCHORR			
19a. INFORMANT'S NAME (Type/Print) MARGARET DAVIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 OAK AVENUE, BALTIMORE, MD. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY 10/19/94		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis b. Infected Decubitus Ulcer c. Old Cerebral Vascular Accident d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Influenza Dependent Cerebral Meltdown							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Attending Doctor				29c. LICENSE NUMBER D21684		29d. DATE SIGNED (Month, Day, Year) 10-15-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHACKUMKAL V. CYRIAC, M.D./1600 CRAIN HIGHWAY, SW #106/GLEN BURNIE, MARYLAND 2106							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, per item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dorsey 19 Frank 30413

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Anthony Dorsey				2. DATE OF DEATH MONTH DAY YEAR Oct. 14, 1994		3. TIME OF DEATH M									
4. SOCIAL SECURITY NUMBER 218-18-7942		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1926		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 7342 Gunpowder Road				9b. CITY, TOWN OR LOCATION OF DEATH Middle River			9c. COUNTY OF DEATH Baltimore								
RESIDENCE OF DECEDENT				10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River							
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7342 Gunpowder Road		10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) Joseph Dozo				18. MOTHER'S NAME (First, Middle, Maiden Surname)											
19a. INFORMANT'S NAME (Type/Print) Emma Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7342 Gunpowder Road Baltimore MD. 21220											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10/17/94		20c. LOCATION — City or Town, State Baltimore MD.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cholangio Carcinoma Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death 2 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Paul Cervenko M.D.		29c. LICENSE NUMBER D30929		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CERVENKO #205-6565 10 Charles ST, BALT MD 21204															
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Sandom-Russell											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is missing, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

61



4



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER				2. DATE OF DEATH MONTH OCT DAY 14 YEAR 94				3. TIME OF DEATH 11:15 P.	
4. SOCIAL SECURITY NUMBER 217-24-1888		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-04-31		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not Institution, give street and number) 907 ARGONNE DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH NONE	
10a. STATE MARYLAND				10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 907 ARGONNE DRIVE				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DIETICIAN		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY					
17. FATHER'S NAME (First, Middle, Last) SAMUEL ADAMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE					
19a. INFORMANT'S NAME (Type/Print) MARSHA WORTHINGTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 FRANKLIN ST. 1st Flr. Watertown, N.Y. 13601					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS CEM. OWINGS MILLS, MD		20c. LOCATION — City or Town, State 10/20/94		20d. LOCATION — City or Town, State 1412 E. PRESTON ST. BALTO, MD. 21213			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i>				22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE				Approximate Interval Between Onset and Death					
Sequitantly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				inspector					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 15, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING				111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>Julia B. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30415

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEATRICE AKA BESSIE FISCHER				2. DATE OF DEATH OCTOBER 14, 1994		3. TIME OF DEATH 3:15 AM	
4. SOCIAL SECURITY NUMBER 216-54-3230		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 26, 1905	
9a. FACILITY NAME (If not institution, give street and number) PIKESVILLE NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3602 FORDS LANE, APT. B			
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) MORRIS FELD				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA KLEEN			
19a. INFORMANT'S NAME (Type/Print) MR. ROBERT FISCHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 NORRIS RUN CT. REISTERSTOWN, MD 21136			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) TIFERETH ISRAEL ANSHE SFARD 10-16-94 ROSEDALE, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gray May Lee</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Myocardial infarct</i> dUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic severe coronary disease</i> dUE TO (OR AS A CONSEQUENCE OF): c. dUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>Acute</i> <i>many years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold B. Bob</i> MD				29c. LICENSE NUMBER D15872		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harold B. Bob MD 7220 Park Heights Ave 21208							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30416

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ferdinand Casper Grine				2. DATE OF DEATH MONTH DAY YEAR October 16 1994				3. TIME OF DEATH M 959	
4. SOCIAL SECURITY NUMBER 216-05-2888		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8, 10, 1911		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH	
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3623 COOLIDGE AVENUE				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST		16b. KIND OF BUSINESS/INDUSTRY DEPT OF DEFENSE					
17. FATHER'S NAME (First, Middle, Last) FRANK CASPER GRINE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELISE EITERMILLER					
19a. INFORMANT'S NAME (Type/Print) CHARLOTTE L. GRINE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 COOLIDGE AVENUE - BALTIMORE, MD. 21229					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 10/20		20c. LOCATION — City or Town, State BALTIMORE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Heaf Coleman				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 3 days 15 yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Suberme						29c. LICENSE NUMBER AL9858	
		29d. DATE SIGNED (Month, Day, Year) 10/16/94						29e. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE John Anderson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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12/11/22

10/10/22

10-23-22

RECEIVED

FROM

Respectfully,
Director of the Bureau of Prisons

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12/11/22

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10/10/22

VOID

CERTIFICATE ✕

94-30417

SEE

CERTIFICATE ✕

94-34912



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94 30418

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Milton Henry GELDMACHER				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 4:35 A M	
4. SOCIAL SECURITY NUMBER 212-10-5459		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 2, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
9b. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				10a. STATE Md.			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Essex			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 354 Montrose Ave.			
10f. ZIP CODE 21221				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Printer				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Printer		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Harry George Geldmacher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Schaefer			
19a. INFORMANT'S NAME (Type/Print) Linda Heier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Montrose Ave. Baltimore MD. 21221			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 10/17/94		20c. LOCATION — City or Town, State Baltimore Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly	
22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 20 minutes			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10/14/94	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND DATE OF CERTIFIER (SAN MIGUEL)		29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) 10/14/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr San Miguel MD. 9000 Franklin Square Drive Baltimore Maryland 21237		31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE [Signature]	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30419

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS GRIFFIN- Thomas Leroy Griffin, Sr.				2. DATE OF DEATH MONTH OCT DAY 13 YEAR 94		3. TIME OF DEATH 11:49 P M	
4. SOCIAL SECURITY NUMBER 523-74-7276		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/24/1950	
8. BIRTHPLACE (State or Foreign Country) N. Carolina				9a. FACILITY NAME (If not institution, give street and number) THE Johns Hopkins Hospital		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE City	
9c. COUNTY OF DEATH -----				10a. STATE Maryland			
10b. COUNTY -----				10c. CITY, TOWN OR LOCATION Balto. City, Md. Rosedale			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1234 Primrose Ave.			
10f. ZIP CODE 21237				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th. Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machanic		16b. KIND OF BUSINESS/INDUSTRY Middleton & Meade			
17. FATHER'S NAME (First, Middle, Last) Leroy S. Griffin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah J. Griffin			
19a. INFORMANT'S NAME (Type/Print) Ms. Michelle D. Tarbet				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 Stieger Way, Balto. Md. 21205			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, temporary or other place) Cedar Hill Cemt. 10/18/94		20c. LOCATION — City or Town, State A.A. Co. Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harold A. Taylor	
22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. immunosuppression DUE TO (OR AS A CONSEQUENCE OF): c. Right lung transplant DUE TO (OR AS A CONSEQUENCE OF): d. pulmonary hypertension				Approximate Interval Between Onset and Death 12 d. 12 d. 12 d. 43 yr.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cardiac - ventricular septal defect				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Mark E. Petriles, M.D. Cicu Surgical Resident			
29c. LICENSE NUMBER 1601				29d. DATE SIGNED (Month, Day, Year) 10/14/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK E. PETRILES, M.D. Johns Hopkins Hospital Baltimore, MD							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John S. R. R. R.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30420

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GILDARDO GARCIA		2. DATE OF DEATH MONTH DAY YEAR OCTOBER 5, 1994		3. TIME OF DEATH 10:30 P M	
4. SOCIAL SECURITY NUMBER 594 70 2924		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 41 YRS.	
9a. FACILITY NAME (If not institution, give street and number) Prince George County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George Co	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Prince Geo Co		10c. CITY, TOWN OR LOCATION Riverdale	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5415 55th Place #202		10f. ZIP CODE 20737	
10g. CITIZEN OF WHAT COUNTRY? Mexico		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Hispanic		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Migrant Worker		16b. KIND OF BUSINESS/INDUSTRY Agriculture			
17. FATHER'S NAME (First, Middle, Last) Jose Garcia			18. MOTHER'S NAME (First, Middle, Maiden Surname) Eulalia Sanchez		
19a. INFORMANT'S NAME (Type/Print) Ronald Wade			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i>		22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cryptococcal meningitis - Tuberculosis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. AIDS c. See above d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AIDS					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jahid Doree, MD</i>		29c. LICENSE NUMBER D32761		29d. DATE SIGNED (Month, Day, Year) 10-06-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Prince George's Hospital - 3001 Hospital Dr. Cheverly - MD. 20785					
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>Michael R. Ball</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30421

ITEM: 1. PER F.H. FILM G-716 10/18/94 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS GERALD HUGHES, SR. THOMAS G. HUGHES				2. DATE OF DEATH MONTH OCT DAY 14 YEAR 1994		3. TIME OF DEATH 6:10 pm	
4. SOCIAL SECURITY NUMBER 215-14-0647		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 25, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Timonium	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 33 Hathaway Road				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer		16b. KIND OF BUSINESS/INDUSTRY Ammunition			
17. FATHER'S NAME (First, Middle, Last) Timothy Joseph Hughes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ann Mulry			
19a. INFORMANT'S NAME (Type/Print) Genevieve A. Hughes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Hathaway Road, Timonium, MD 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. 10/18		20c. LOCATION — City or Town, State Timonium, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary				22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 12 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES CLAUDICATION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Raymond H. Plack, Jr., M.D.				29c. LICENSE NUMBER D32319		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAYMOND H. PLACK, JR., M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John D. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 30422

ITEMS: 2. & 3. PER DR. FILM G-716 10/18/94 t.t

ITEM: 23 part I, per M.O. & MEO G-720 2/14/95 reb

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna Hoesch				2. DATE OF DEATH MONTH 9 DAY 24 YEAR 94		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 220-74-9442		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 26, 1908	
8. BIRTHPLACE (State or Foreign Country) Baltimore City				9a. FACILITY NAME (If not institution, give street and number) 2513 Crestview Drive		9b. CITY, TOWN OR LOCATION OF DEATH Fallston	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Fallston				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2513 Crestview Drive	
10f. ZIP CODE 21047				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Joseph Ulsch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Kues			
19a. INFORMANT'S NAME (Type/Print) Anne Schneider				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2514 Crestview Drive Fallston, Md. 21047			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum 9/27/94		20c. LOCATION — City or Town, State Towson, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>				22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Probable Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 0
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Haswell MD</i>				29c. LICENSE NUMBER D34652		29d. DATE SIGNED (Month, Day, Year) 9-26-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. HASWELL 2 N. AVE SUITE 101 Bel Air MD 21014							
31. DATE FILED (Month, Day, Year) SEP 28 1994				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SS:155

SS:155

SS:155

[Faint, illegible handwriting on lined paper]

94 30423

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY L. HOUSEMAN				2. DATE OF DEATH MONTH 10 DAY 17 YEAR 94		3. TIME OF DEATH 2 a. M	
4. SOCIAL SECURITY NUMBER 212-78-3365		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-31-16	
9a. FACILITY NAME (If not institution, give street and number) Bay Meadow Nsg./Rehab Center				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7355 Furnace Branch Rd., E.-Glen Burnie, Md.				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Albert Houseman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian R. Stedding			
19a. INFORMANT'S NAME (Type/Print) John C. Houseman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt.1-Box 249-Oldtown, Md. 21555			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 10-18-94		20c. LOCATION — City or Town, State Baltimore, Md.		20d. DATE 10-18-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Baltimore, Md. 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Heart Failure Complicated Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Respiratory Failure Shock							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vascular Disease Hypertension							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Heidi K. Koonen				29c. LICENSE NUMBER 017753		29d. DATE SIGNED (Month, Day, Year) 10/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE J. J. J. J.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30424

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>David Hall</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>16</i> YEAR <i>94</i>		3. TIME OF DEATH <i>3:45 PM</i>	
4. SOCIAL SECURITY NUMBER <i>213 10 9563</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept 26, 1921</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Denten Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Md.</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>601 S. Charles Street</i>	
10f. ZIP CODE <i>21230</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>10</i> College (1-4 or 5+) <i>UNK.</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNK.</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>UNK.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>UNK.</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Angelia Mc Knight</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>861 Park Ave. Baltimore, MD. 21201</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Zion Cem. 10-18-94</i>		20c. LOCATION — City or Town, State <i>Lansdowne, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Albert P. Wylie F/HPA</i>				22. NAME AND ADDRESS OF FACILITY <i>638 N. Baltimore, MD. 21217</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): a. <i>Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>C.V.A.</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>C.V.A.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DEEP VEIN THROMBOSIS</i> <i>L.L. Beckwith</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. P. Wylie, Attending Physician</i>				29c. LICENSE NUMBER <i>213248</i>		29d. DATE SIGNED (Month, Day, Year) <i>10-16-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>AJ Hall 5510 N. ... 5000 ...</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 18 1994</i>				32. REGISTRAR'S SIGNATURE <i>John ...</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30425

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES M ERMVIELLE HAYNES				2. DATE OF DEATH MONTH 10 DAY 17 YEAR 94		3. TIME OF DEATH 09:55 AM	
4. SOCIAL SECURITY NUMBER 540-18-8473		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-24-1919	
8. BIRTHPLACE (State or Foreign Country) OREGON				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 802 GEIS CIRCLE	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AUTO MECHANIC				16b. KIND OF BUSINESS/INDUSTRY HERTZ			
17. FATHER'S NAME (First, Middle, Last) HERBERT HARRY HAYNES				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE FRANCES ARRINGTON			
19a. INFORMANT'S NAME (Type/Print) CATHERINE HARMON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 GEIS CIRCLE, GLEN BURNIE, MD. 21061			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP CREMATORY			
20c. LOCATION — City or Town, State 10/21/1994 TOWSON, MARYLAND				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Decubitus ulcer Diabetes mellitus			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 10/17/94			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 038958			
29d. DATE SIGNED (Month, Day, Year) 10/17/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DALJEET S. SIDHU, M.D./1413 ANNAPOLIS ROAD, #106/ODENTON, MARYLAND 21113			
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked as "Other" shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30426

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NORMAN L UTHER HAMBY				2. DATE OF DEATH 10 TH 17 ^{DAY} 94 ^{YEAR}		3. TIME OF DEATH 02:30 AM	
4. SOCIAL SECURITY NUMBER 248-34-0062		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-21-1926	
8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8080 GREEN BUD LANE, APT. T1	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERGY		16b. KIND OF BUSINESS/INDUSTRY HERITAGE CHURCH	
17. FATHER'S NAME (First, Middle, Last) WILLIAM TROY HAMBY				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN GREER			
19a. INFORMANT'S NAME (Type/Print) CLARA F. HAMBY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 21061 8080 GREEN BUD LANE, APT. T1, GLEN BURNIE,			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD. VETERANS CEMETERY 10/20/1994		20c. LOCATION — City or Town, State CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Bilateral infiltrates - Congestive heart failure versus pneumonia.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>metastatic rectal carcinoma.</i> c. <i>Anasarca hypo-albuminemia.</i> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benjamin A. Deguzman, M.D.</i>				29c. LICENSE NUMBER DD3648		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BENJAMIN DEGUZMAN, M.D./6320 RITCHIE HIGHWAY, SUITE 1/GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, the medical examiner must be notified at once.

94 30427

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Calvin Hook Sr.				2. DATE OF DEATH MONTH DAY YEAR October 17, 1994		3. TIME OF DEATH 1:36 AM	
4. SOCIAL SECURITY NUMBER 214-05-3490		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 7, 1914	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
10a. STATE Md.				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3703 F. Pennylane				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dispatcher		17. KIND OF BUSINESS/INDUSTRY Trucking Co.			
17. FATHER'S NAME (First, Middle, Last) Harry Franklin Hook				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lenore Dill			
19a. INFORMANT'S NAME (Type/Print) Marie Hook				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 F. Penny Lane Abingdon Md. 21009			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 10/20/94 Baltimore MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connolly				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. GVA ASCVD Seizure disorder f. COOP g. peripheral vascular d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. T. Lee M.D.				29c. LICENSE NUMBER D20661		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. T. Lee M.D. 307 S. Union Ave. Havre de Grace MD							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Anderson Registrar			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPROPER FILING OF THIS FORM MAY BE PENALIZED.



7

94 30428

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard John Jacobs Sr.				2. DATE OF DEATH MONTH DAY YEAR October 16 1994		3. TIME OF DEATH 1:00 a m	
4. SOCIAL SECURITY NUMBER 218-03-9503		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 4 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 225 West Medwick Garth		9b. CITY, TOWN OR LOCATION OF DEATH Catonsville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Catonsville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 225 West Medwick Garth	
10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Technician		16b. KIND OF BUSINESS/INDUSTRY Westinghouse	
17. FATHER'S NAME (First, Middle, Last) Mordecia Jacobs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora E. [Shumann]			
19a. INFORMANT'S NAME (Type/Print) Marie Jacobs (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 West Medwick Garth Catonsville Maryland 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Cemetery October 19, 1994		20c. LOCATION — City or Town, State Marriottsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Craig Witzke Jr.				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Ave. Catonsville MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non-Hodgkins Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 YRS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Diana H. Griffiths MD				29c. LICENSE NUMBER D19419		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIANA H. GRIFFITHS 900 CATON AVE. BALI. MD 21229							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Shuster			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30429

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GRACE THOMAS JACKLEY				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH 9:17 A.M.	
4. SOCIAL SECURITY NUMBER 212-01-1870		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) 8/5/04 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 5, 1904	
9a. FACILITY NAME (If not institution, give street and number) PICKERSGILL				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION TOWSON		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 615 CHESTNUT AVENUE				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) HARRY THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE HUDSON			
19a. INFORMANT'S NAME (Type/Print) PICKERSGILL, INC.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 CHESTNUT AVENUE TOWSON, MD. 21204			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) MOUNTAIN VIEW CEM. 10/19/94		20c. LOCATION — City or Town, State MARRIOTTSTVILLE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Delon</i>				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ISCHEMIC HEART DISEASE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ATHEROSCLEROSIS DEPRESSION TRIGEMINAL NEURALGIA							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEPRESSION TRIGEMINAL NEURALGIA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eugene A. O'BAH MD</i>				29c. LICENSE NUMBER D44018		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EUGENE A. O'BAH 6565 N. CHARLES STREET BALTO MD 21204							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John E. Delon</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30430

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM ROBERT JONES				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 1994		3. TIME OF DEATH 4:00 P. M.	
4. SOCIAL SECURITY NUMBER 232-30-2786		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-22-1910	
9a. FACILITY NAME (If not institution, give street and number) 789 PAUL BIRCH DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH CROWNSVILLE		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION CROWNSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 789 PAUL BIRCH DRIVE				10f. ZIP CODE 21032		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ATTENDANT		16b. KIND OF BUSINESS/INDUSTRY CROWNSVILLE STATE HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) ARDELIOUS JONES				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA OWENS			
19a. INFORMANT'S NAME (Type/Print) MRS. BEVERLY A. WASHINGTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 760 OLD HERALD HARBOR RD. CROWNSVILLE, MD. 21032			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PK 10/19/94		20c. LOCATION — City or Town, State GLEN BURNIE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 05357		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 18 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30431

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HYONG SUN KIM				2. DATE OF DEATH MONTH 10 - DAY 16 - YEAR 94		3. TIME OF DEATH 2:35 P M	
4. SOCIAL SECURITY NUMBER 225-04-1827		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 5 1927	
8. BIRTHPLACE (State or Foreign Country) KOREA				9a. FACILITY NAME (If not institution, give street and number) LORIEN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA	
9c. COUNTY OF DEATH HOWARD				10a. STATE MD		10b. COUNTY HOWARD	
10c. CITY, TOWN OR LOCATION COLUMBIA				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6334 CEDAR LANE, LORIEN NURSING HOME	
10f. ZIP CODE 21044		10g. CITIZEN OF WHAT COUNTRY? KOREA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: KOREAN		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANICS ASSISTANT				16b. KIND OF BUSINESS/INDUSTRY AUTOMOBILE		17. FATHER'S NAME (First, Middle, Last) UNKNOWN	
18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN				19a. INFORMANT'S NAME (Type/Print) CHAE UN KIM (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7964 BRIGHTMEADOW COURT, ELLICOTT CITY, MD 21043	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CRESTLAWN CEMETERY 10-20-94		20c. LOCATION — City or Town, State MARRIOTTSVILLE, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD COLUMBIA MD 21045				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): insulin dependent diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): High blood pressure DUE TO (OR AS A CONSEQUENCE OF): Cerebral arterio sclerosis		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebro Vascular disease				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D31575	
29d. DATE SIGNED (Month, Day, Year) 10/17/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) KOLODRUBETZ 9501 Ward Annapolis Road Ellicott City		31. DATE FILED (Month, Day, Year) OCT 18 1994	
32. REGISTRAR'S SIGNATURE 				33. M.D. 21042			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30432

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SUZANNE KESSLER				2. DATE OF DEATH MONTH 10 - DAY 12 - YEAR 94		3. TIME OF DEATH 7:20 P. M	
4. SOCIAL SECURITY NUMBER 117-05-7362		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1897	
9a. FACILITY NAME (If not institution, give street and number) Levindale				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 524 N. Charles St, Apt. 801		10f. ZIP CODE 21201	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Buyer				16b. KIND OF BUSINESS/INDUSTRY Ladies Clothes		17. FATHER'S NAME (First, Middle, Last) Louis Rubin	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Titen				19a. INFORMANT'S NAME (Type/Print) Mrs. Evelyn Kessler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 N. Charles St., apt. 801 Balto., MD 21201	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington-Chizuk Amuno 10-14-94 Baltimore, md		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Cottle</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE CHRONIC DUE TO (OR AS A CONSEQUENCE OF): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate interval Between Onset and Death		Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE SENILE DEMENTIA, MULTI-INFARCT TYPE				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Seton</i> ATTENDING PHYSICIAN		29c. LICENSE NUMBER D 25610	
29d. DATE SIGNED (Month, Day, Year) 10-13-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SET HITWAR LEVINDALE, 2434 W. BELVERDERE AVENUE, BALTIMORE, MD 21215		31. DATE FILED (Month, Day, Year) OCT 18 1994	
32. REGISTRAR'S SIGNATURE <i>Julia Bruckner Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30433

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET VIRGINIA KERWATH				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 1994		3. TIME OF DEATH 7:30 A. M	
4. SOCIAL SECURITY NUMBER 216-05-0875		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	7. DATE OF BIRTH MONTH 02 DAY 06 YEAR 1922		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION HANOVER		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7412 LOCUST DRIVE				10f. ZIP CODE 21076		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSEMBLY WORKER		16b. KIND OF BUSINESS/INDUSTRY WESTINGHOUSE			
17. FATHER'S NAME (First, Middle, Last) CHARLES DONNELLY				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA MILLER			
19a. INFORMANT'S NAME (Type/Print) REGINA ELIZABETH DUNAWAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7414 LOCUST DRIVE, HANOVER, MARYLAND 21076			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK 10/18/94		20c. LOCATION — City or Town, State ELKRIDGE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, SW GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>D. 4 B. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D19151		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GLENN ROBBINS 1600 CRAIN HWY STE #302 GLEN BURNIE, MD. 21061							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30434

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIA ANTONIETTA LAMBERTI				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 10:15A M	
4. SOCIAL SECURITY NUMBER 220-80-6499		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4 15 14	
9a. FACILITY NAME (If not institution, give street and number) 3544 LYNDALE AVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTO 21213 Md.		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTO. MD.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3544 LYNDALE AVE				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 2 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) CARMINE Dilisi				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH CAVALANO			
19a. INFORMANT'S NAME (Type/Print) RITA LAMBERTI				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3544 LYNDALE AVE BALTO 21213 Md.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, brother, etc.) HOLY REDEEMER 10/18		20c. LOCATION — City or Town, State BALTO MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE CORONARY ARTERY INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph D. Notarangelo M.D.</i>				29c. LICENSE NUMBER D07316		29d. DATE SIGNED (Month, Day, Year) OCT-17-1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30435

Item # 1,10f,11,14 film # G 716 10-18-94 N.A. Per Funeral Home

FOR
1. STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Harrell K Lancaster</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>14</u> YEAR <u>94</u>		3. TIME OF DEATH <u>8:55 A</u> M	
4. SOCIAL SECURITY NUMBER <u>235-05-8206</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>08/15/14</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Center ECF</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>1</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD</u>		10b. COUNTY <u>Glen Burnie</u>		10c. CITY, TOWN OR LOCATION <u>Glen Burnie</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>7524 Balto + Annapolis Blvd</u>				10f. ZIP CODE <u>21061</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>NONE</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>SELF EMPLOYED</u>		16b. KIND OF BUSINESS/INDUSTRY <u>SERVICE STATION</u>			
17. FATHER'S NAME (First, Middle, Last) <u>ALBERT K. LANCASTER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARY E. VINES</u>			
19a. INFORMANT'S NAME (Type/Print) <u>MR. LARRY K. LANCASTER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1726 SWINBURNE AVENUE, CROFTON, MD. 21114</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GLEN HAVEN MEMORIAL PARK 1994</u>		20c. LOCATION — City or Town, State <u>GLEN BURNIE, MD.</u>		20d. DATE <u>10/17</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Myocardial Infarction Complicated by Atherosclerosis</u> Approximate interval between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Prostate Cancer, Osteoarthritis, Hypertension</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify <u>Extended Care Facility</u>)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Russell A. DeLuna</u>		29c. LICENSE NUMBER <u>031351</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/14/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Russell A. DeLuna M.D. 3001 S. Hanover St, Baltimore, Md. 21225</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 18 1994</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30436

ITEM: 17. PER F.H. FILM G-716 10/18/94 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN				2. DATE OF DEATH MONTH OCTOBER DAY 14 YEAR 1994				3. TIME OF DEATH 10:40 AM	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) JULY 14, 1907		8. BIRTHPLACE (State or Foreign Country) POLAND			
9a. FACILITY NAME (If not institution, give street and number) SINAT HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH	
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5535 GIST AVE.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER				16b. KIND OF BUSINESS/INDUSTRY CLOTHING			
17. FATHER'S NAME (First, Middle, Last) MORRIS ROTSTEIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) RIVKA GOLDSMITH					
19a. INFORMANT'S NAME (Type/Print) MR. JOSEPH MARCUS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5535 GIST AVE BALTIMORE, MD 21215					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EIFERETH ISRAEL ANSHE SFARD				DATE 10-16-94		20c. LOCATION — City or Town, State ROSEDALE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Valvular heart disease b. Arrhythmia c. Chronic renal failure d. Chronic renal failure								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 300379		29d. DATE SIGNED (Month, Day, Year) 10/14/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MILAN WISTER, MD 19 WALKER AVE, BALTIMORE, MD 21208									
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30437

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Russell A. Myers				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 9.15 P M	
4. SOCIAL SECURITY NUMBER 212-22-7271		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-28-26	
9a. FACILITY NAME (If not institution, give street and number) Bon Secour Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Md.				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5031 Frederick Avenue-Baltimore, Md.			
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Sheet Metal Worker		16b. KIND OF BUSINESS/INDUSTRY Atlas Sheet Metal			
17. FATHER'S NAME (First, Middle, Last) John Myers				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN ?			
19a. INFORMANT'S NAME (Type/Print) Dorothy T. Myers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5031 Frederick Avenue-Baltimore, Md. 21229			
20a. METHOD OF DISPOSITION 10-18-94 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 10-18-94		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab				22. NAME AND ADDRESS OF FACILITY 3512 Frederick Avenue Baltimore, Md. 21229			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Endstage Metastatic lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Hypercalcemia DUE TO (OR AS A CONSEQUENCE OF): c. Dehydration DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kerren Eldermy House officer				29c. LICENSE NUMBER D38993		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kerren Eldermy 410 West Lombard St Baltimore MD 21201							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23a is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30438

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIO F. MERCURIO				2. DATE OF DEATH MONTH 10 - DAY 16 - YEAR 94		3. TIME OF DEATH 4:00 AM	
4. SOCIAL SECURITY NUMBER 215-10-5553		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) FEB. 21, 1910		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not Institution, give street and number) Howard County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1415 Haberson Road				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Shop Foreman		16b. KIND OF BUSINESS/INDUSTRY Machine Shop			
17. FATHER'S NAME (First, Middle, Last) Vincent Mercurio				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madeline Treisonno			
19a. INFORMANT'S NAME (Type/Print) Shirley M. Mercurio				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Harberson Road Catonsville Maryland 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Cemetery		DATE Oct. 19, 1994		20c. LOCATION — City or Town, State Sykesville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Ave. Catonsville Maryland 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death days
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Intrathoracic liposarcoma							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D36845		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAI-CHI NGUYEN, MD 11055 LITTLE PATUXENT PKWY, #107, COLUMBIA, MD 21044							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


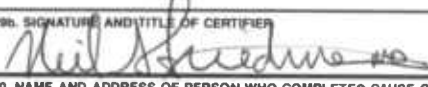
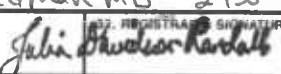
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30439

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leon Melen				2. DATE OF DEATH MONTH DAY YEAR Oct 14, 1994				3. TIME OF DEATH 4:00 P M				
4. SOCIAL SECURITY NUMBER				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-16-1921		8. BIRTHPLACE (State or Foreign Country) POLAND		
9a. FACILITY NAME (If not institution, give street and number) 3813 Menlo Drive						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT						10c. CITY, TOWN OR LOCATION BROOKLYN			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10a. STATE NY		10b. COUNTY		10e. STREET AND NUMBER 1775 E. 7TH STREET				10f. ZIP CODE 11230		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) MAINTENANCE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE				16b. KIND OF BUSINESS/INDUSTRY XEROX CORP.				
17. FATHER'S NAME (First, Middle, Last) SHMUEL MELEN						18. MOTHER'S NAME (First, Middle, Maiden Surname) CHAYALIEBA						
19a. INFORMANT'S NAME (Type/Print) MR. IRWIN SCHMELL						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3813 MENLO DR., BALTIMORE, MD 21215						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BATHURST LAWN 10-17-94				20c. LOCATION — City or Town, State TORONTO, CANADA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. 6010 REISTERSTOWN RD., BALTIMORE, MD 21215						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced Non Small Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 10 months		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Heart Disease History of Prostate Cancer										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 042178		29d. DATE SIGNED (Month, Day, Year) 10/14/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Neil S. Friedman MD 2435 W. Belvedere Ste. 23 Balto, MD 21215												
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.


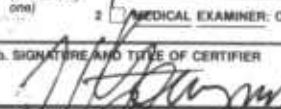
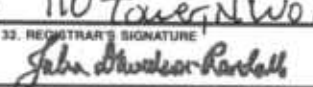
DHMH-18 Rev 1/89

Admission 10

94 30441

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES E MENSCH SR. Charles Elias Mensch Sr.				2. DATE OF DEATH MONTH October DAY 12 YEAR 1994		3. TIME OF DEATH 01:11 a.m.	
4. SOCIAL SECURITY NUMBER 218-36-4148		5. SEX XXX M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-11-1940	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND			
10b. COUNTY ANNE ARUNDEL				10c. CITY, TOWN OR LOCATION GLEN BURNIE			
10d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 923 SUNNYBROOK DRIVE			
10f. ZIP CODE 21060				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) NONE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSISTANT FOREMAN		15b. KIND OF BUSINESS/INDUSTRY BALTIMORE AIRCOIL COMPANY			
17. FATHER'S NAME (First, Middle, Last) ALBERT C. MENSCH				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM BLEACHMAN			
19a. INFORMANT'S NAME (Type/Print) BETTY MENSCH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 SUNNYBROOK DRIVE, GLEN BURNIE, MD. 21060			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK DATE 10/15/1994		20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Pneumonia c. Immunosuppression d. Glioblastoma multiforme							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TYPE OF CERTIFIER 				29c. LICENSE NUMBER M6217		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. H. Yang 110 Tower, N. Wolf St Baltimore MD							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL NORMAN MCCALL				2. DATE OF DEATH MONTH DAY YEAR OCT 16 1994		3. TIME OF DEATH 10:40 PM	
4. SOCIAL SECURITY NUMBER 212-62-9082		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1957	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 2909 EASTERN BLVD		10. CITY, TOWN OR LOCATION OF DEATH ESSEX	
11. COUNTY OF DEATH BALTIMORE				12. RESIDENCE OF DECEDENT			
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3605 Dahlia Lane				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steelworker		17. KIND OF BUSINESS/INDUSTRY Beth Steel			
18. FATHER'S NAME (First, Middle, Last) Norman McCall				19. MOTHER'S NAME (First, Middle, Maiden Surname) Lorraine Broda			
20. INFORMANT'S NAME (Type/Print) Nancy McCall				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Dahlia Lane Baltimore MD. 21220			
22a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		22b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery 10/20/94 Baltimore MD.		22c. LOCATION — City or Town, State			
23. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connolly				24. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221			
25. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Head Injuries Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
27. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				28. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
30. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		31. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
32. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		33. DATE OF INJURY (Month, Day, Year) 10-16-94		34. TIME OF INJURY 2:28 PM		35. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
36. DESCRIBE HOW INJURY OCCURRED motor vehicle accident		37. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2909 Eastern Blvd Baltimore Co Md					
38. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
39. SIGNATURE AND TITLE OF CERTIFIER Norman J. Chute MD				40. LICENSE NUMBER O.C.M.E.		41. DATE SIGNED (Month, Day, Year) OCT 17, 1994	
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
43. DATE FILED (Month, Day, Year) OCT 18 1994		44. REGISTRAR'S SIGNATURE Justin...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30443

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMMA MURRAY				2. DATE OF DEATH MONTH DAY YEAR 10-14-94		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 246-38-4252		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 67 YRS.	7. DATE OF BIRTH (Month, Day, Year) 04-15-27		8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) 2707 E. PRESTON ST.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH NONE	
10a. STATE MARYLAND		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2707 E. PRESTON STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPER		16b. KIND OF BUSINESS/INDUSTRY MARYLAND GENERAL HOSP.			
17. FATHER'S NAME (First, Middle, Last) HERBERT LUCAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA SADDLER			
19a. INFORMANT'S NAME (Type/Print) DIANA JOHNSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 CRESTVIEW RD. BALTIMORE, MD. 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 10/19/94		20c. LOCATION — City or Town, State BALTIMORE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Colonic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST chronic hypertension DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. [Signature]</i>				29c. LICENSE NUMBER D30641		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30444

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SELDON HARRY NICHOLSON				2. DATE OF DEATH MONTH DAY YEAR October 14, 1994		3. TIME OF DEATH 9:40 A. M	
4. SOCIAL SECURITY NUMBER 218-07-9410		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 10, 1907	
9a. FACILITY NAME (If not institution, give street and number) Ashburton Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2714 Woodsdale Avenue				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Oscar Nicholson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Martin			
19a. INFORMANT'S NAME (Type/Print) Mr. Hugh M. Nicholson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 Woodsdale Avenue Baltimore, Maryland 21214			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corporation 10/15/94		20c. LOCATION — City or Town, State Towson Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Cancer of Rectum with Metastasis							
DUE TO (OR AS A CONSEQUENCE OF):							
b. ASCVD							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Arthritis							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death 6 months							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Macht MD				29c. LICENSE NUMBER 023603		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Macht 101 W. Read Street							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If information is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30445

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PALMER L NEWMAN				2. DATE OF DEATH MONTH 10 DAY 17 YEAR 94		3. TIME OF DEATH 12:38 AM	
4. SOCIAL SECURITY NUMBER 225-18-8058		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01 31 20	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9. COUNTY OF DEATH A.A. COUNTY			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE			
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7689 SANDY FARM ROAD			
10f. ZIP CODE 21144				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 11		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHAUFFEUR		16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION			
17. FATHER'S NAME (First, Middle, Last) CHARLES NEWMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LIZZIE ELIZABETH MINK			
19a. INFORMANT'S NAME (Type/Print) MARGARET M. NEWMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7689 SANDY FARM RD-SEVERN, MD. 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS		20c. LOCATION — City or Town, State 10/20 CROWNSVILLE, MD.		20d. DATE 10/20	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ray L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Cerebral Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Generalized Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation Seizure Disorders, Multiple Cerebral Infarcts							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard E. Fisher MD</i>				29c. LICENSE NUMBER DO 2519		29d. DATE SIGNED (Month, Day, Year) Oct 17 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD E. FISHER, M.D./4710 PENNINGTON AVENUE/BALTIMORE MARYLAND 21226							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John Benson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30446

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mollie E. Norris				2. DATE OF DEATH MONTH 10/16 DAY 1994 YEAR		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 232-01-9141		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH MONTH 3 DAY 15 YEAR 1911		8. BIRTHPLACE (State or Foreign Country) W. Virginia	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie, Md.		9c. COUNTY OF DEATH A.A.Co.Md.	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY A.A.Co.		10c. CITY, TOWN OR LOCATION Glen Burnie, Md.		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 507 Kent Circle				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bar Owner		16b. KIND OF BUSINESS/INDUSTRY Own Business			
17. FATHER'S NAME (First, Middle, Last) Jacob -- Painter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna -- Hardy			
19a. INFORMANT'S NAME (Type/Print) Katherine H. Green				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 West Rd. Balto. Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Glen Haven Memorial Pk. 10/19		20c. LOCATION — City or Town, State Glen Burnie, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 10 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samuel A. Taylor</i>				29c. LICENSE NUMBER MD 26664		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John S. Smith</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5779-510
B.K.S

94 30447

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-717 11/23/94 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN O'CONNELL				2. DATE OF DEATH OCT. 6 1994		3. TIME OF DEATH 10:45 A.M.					
4. SOCIAL SECURITY NUMBER 138-52-2502		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs., last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09 09 57		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH -----			
10a. STATE Maryland		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1342 Crofton Road				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Repair				16b. KIND OF BUSINESS/INDUSTRY Computer					
17. FATHER'S NAME (First, Middle, Last) John O'Connell, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown							
19a. INFORMANT'S NAME (Type/Print) Dolores O'Connell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1342 Crofton Road Balto, MD 21239							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 10/19/94		20c. LOCATION — City or Town, State Balto Co MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.E. Howell				22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Ave Balto, MD 21201							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEAD INJURIES DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 10-4-94		28b. TIME OF INJURY P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King, M.D.				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 7, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Harrison Rucker							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30448

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank A. Pelley				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH 7⁰⁰ A M	
4. SOCIAL SECURITY NUMBER 171-01-5618		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/4/13	
9a. FACILITY NAME (If not institution, give street and number) Bayview Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 415 S. Taylor Ave.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Beth Steel		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Beth Steel		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Stephen Pelley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Podraza			
19a. INFORMANT'S NAME (Type/Print) Geneva Pelley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 S. Taylor Ave. Baltimore Md. 21221			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 10/18/94		20c. LOCATION — City or Town, State Rossville Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → hypercarbic acidosis a. DUE TO (OR AS A CONSEQUENCE OF): b. Emphysema c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 24 hrs 10 yrs						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Robert J. Marshall MD		29c. LICENSE NUMBER 69730		29d. DATE SIGNED (Month, Day, Year) 10/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert J. Marshall MD Tower 110 Johns Hopkins Hospital							
31. DATE FILED (Month, Day, Year) 10/15/94 OCT 18 1994				32. REGISTRAR'S SIGNATURE Julius Anderson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30449

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thelma Roberson				2. DATE OF DEATH MONTH 10 DAY 18 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-32-6319		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 13 34	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2719 Carver Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH -----				10a. STATE Maryland			
10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2719 Carver Road				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) ---		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Various			
17. FATHER'S NAME (First, Middle, Last) Willie C. Stephenson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Doles			
19a. INFORMANT'S NAME (Type/Print) Beatrice Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3031 W. Garrison Av. Balto, MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Calvary Cem. 10/22/94		20c. LOCATION — City or Town, State Glen Burnie, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Ave. Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D25373		29d. DATE SIGNED (Month, Day, Year) 10/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 631 Cherry Hill Rd							
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5949-045

DWG Item11 ITEMS: 23 PART I, 27, PER MEO FILM G-721 3/2/95 t.t

94 30450

Item19a 11-4-94 FilmG717 W.H.Per F/H

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES ROBINSON				2. DATE OF DEATH MONTH DAY YEAR OCT. 15 94		3. TIME OF DEATH 9:33P	
4. SOCIAL SECURITY NUMBER 251-46-4275		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01 02 35	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9. COUNTY OF DEATH WICOMICO			
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1510 East 33 Street				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Armco Steel			
17. FATHER'S NAME (First, Middle, Last) James Robinson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Luvina Robinson			
19a. INFORMANT'S NAME (Type/Print) Marie Mary A. Patton		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 E. 33 St. Balto, MD 21218					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery 10/20/94 Owings Mills, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOE HAWK		22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Ave. Balto, MD 21201					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHOKING COMPLICATING HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Complications Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King M.D.		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT. 17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King		111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE John Danen-Rudolf					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 30451

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KNOWER M. RHODES				2. DATE OF DEATH MONTH 10 DAY 10 YEAR 94		3. TIME OF DEATH 1619 M	
4. SOCIAL SECURITY NUMBER 223-18-6875		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 31, 1915	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Virginia		10b. COUNTY Accomack	
10c. CITY, TOWN OR LOCATION Saxis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P. O. Box # 111	
10f. ZIP CODE 23427				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II.				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) -0-				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Joseph Rhodes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Miles			
19a. INFORMANT'S NAME (Type/Print) Joseph E. Rhodes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Meadow Mist Court - Reisterstown, Md. 21136			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Miles Cemetery 10-13-94		20c. LOCATION — City or Town, State Saxis, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sam B. Elmi				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 11824 Reisterstown Road Reisterstown, Md. 21136			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Rhodes Attending Physician				29c. LICENSE NUMBER D40390		29d. DATE SIGNED (Month, Day, Year) 10/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P.R. DESA, MD, 9017 LIBERTY RD., RANDALLSTOWN, MD 21133							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1

94 30452

ITEM: 17. PER F.H. FILM g-716 10/18/94 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Sewell Richmond				2. DATE OF DEATH MONTH DAY YEAR October 12 1994		3. TIME OF DEATH 2:37 A M	
4. SOCIAL SECURITY NUMBER 212 03 7860		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 29, 1914	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7 SLADE AVE, APT. 115			
10f. ZIP CODE 21208				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHARMACIST		16b. KIND OF BUSINESS/INDUSTRY PHARMACY			
17. FATHER'S NAME (First, Middle, Last) LEWIS LOUIS RICHMOND				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA HANDWERGER			
19a. INFORMANT'S NAME (Type/Print) MRS. EVELYN RICHMOND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 SLADE AVE, APT. 115 BALTIMORE, MD 21208			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO 10-13-94 BALTIMORE, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D Lewis</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Embolus DUE TO (OR AS A CONSEQUENCE OF): b. Small Bowel Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Elizabeth V. Loeb, MD				29c. LICENSE NUMBER AS2402321EL9837		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sinai Hospital 2401 W. Belvedere Baltimore, MD 21215							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John Sanders-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30453

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES ROHDE				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 215-42-2170		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3, 31, 1902	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) 139 Register Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 139 Register Ave.	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Bernard McGarrity				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret O'Brien			
19a. INFORMANT'S NAME (Type/Print) Elizabeth R. Wagner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Register Ave. Baltimore, Md. 21212			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 10/18/94		20c. LOCATION — City or Town, State Towson, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2. Pulmonary vascular accident 2. Coronary Heart Disease						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D14959		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Felix Tan, M.D. 4000 Erdman Ave. Baltimore, Md.							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30454

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Richards				2. DATE OF DEATH MONTH DAY YEAR OCT 13 1994		3. TIME OF DEATH 10:15 A.M.	
4. SOCIAL SECURITY NUMBER 213-07-4955		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 11, 1916	
9a. FACILITY NAME (If not institution, give street and number) Joseph Richey Hospic				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 4105 Lorraine Ave.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Emmett Richards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida ==			
19a. INFORMANT'S NAME (Type/Print) Edna Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Lorraine Ave. Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 10/17/94		20c. LOCATION — City or Town, State Baltimore MD.		20d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Tully Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Distant Metastasis							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Lung Adenocarcinoma							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel Finkelstein MD				29c. LICENSE NUMBER DE 33		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel Finkelstein 1907 South Rd Balt Md 21209							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE John D. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

REG. NO.

DHMH-16 Rev 1/89

100-100000

100-100000



94 30456

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rao Frances KATE RAO				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 7:00 A M	
4. SOCIAL SECURITY NUMBER 414 34 7401		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05-22-24	
8a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH na	
9a. STATE Maryland				9b. COUNTY Baltimore		9c. CITY, TOWN OR LOCATION Baltimore	
10a. STREET AND NUMBER 6 Stardust Court				10b. ZIP CODE 21228		10c. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) George Roy Rakestraw				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Edna Daugherty			
19a. INFORMANT'S NAME (Type/Print) Dr. Rao				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Stardust Court, Baltimore, MD 21228			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore Street, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. overwhelming infection							
b. embolic stroke							
c. chronic atrial fibrillation							
d. valvular heart disease							
Approximate Interval Between Onset and Death 2 days 6 days 5 years 20 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No Breast Cancer Thyroid Nodule Prior Stroke							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J A Bellan MD					
29c. LICENSE NUMBER Johns Hopkins 4662		29d. DATE SIGNED (Month, Day, Year) 10/12/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J A Bellan MD 600 N Wolfe St Baltimore MD 21205							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE Markus Radloff					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30457

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CECELIA S. SLUNT				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1994		3. TIME OF DEATH 4:05 P.M.	
4. SOCIAL SECURITY NUMBER 216-01-4093D		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 2, 1904	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME (SEVERNA PK)				9b. CITY, TOWN OR LOCATION OF DEATH SEVERNA PARK		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION LINTHICUM		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 512 HEATH AVENUE				10f. ZIP CODE 21090		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H/S GRAD		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING			
17. FATHER'S NAME (First, Middle, Last) MORRIS STEINBERG				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARY			
19a. INFORMANT'S NAME (Type/Print) PAUL SLUNT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 658 LAUREL PLACE - SEVERNA PARK, MD. 21146-3420			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CREMATORY		DATE 10/18		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie D. Shannon</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Multi-infarct demencia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D41927		29d. DATE SIGNED (Month, Day, Year) 10/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George Keren - ALAND, MD 3708 Mountain Road Pasadena, MD 21122							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30458

ITEM: 1. PER F.H. FILM G-716 10/18/94 t.t

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Emma Katherine Simpson</i>		2. DATE OF DEATH MONTH DAY YEAR <i>10 12 94</i>		3. TIME OF DEATH <i>1:35 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-58-3779</i>		5. SEX <i>1</i> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>91</i> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital - Broadway Wing</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <i>MARYLAND</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>100 North Broadway</i>		10f. ZIP CODE <i>21231</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <i>3</i> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8</i> Elementary/Secondary (0-12) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>		17. FATHER'S NAME (First, Middle, Last) <i>Ludolph Bosley Vocke</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ellen Rayfield Jordan Bishop</i>		19a. INFORMANT'S NAME (Type/Print) <i>E. Katherine Mead</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>86 Padonia Rd., Apt. 204, Timonium, MD 21093</i>	
20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Baltimore Cemetery</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bryan W. Clary</i>		22. NAME AND ADDRESS OF FACILITY <i>LEMMON FUNERAL HOME</i> <i>10 W. Padonia Rd., Timonium, MD 21093</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): <i>Urinary infection</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Advanced Alzheimer</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <i>1</i> <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <i>3</i> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <i>1</i> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elia Abboud M.D.</i>		29c. LICENSE NUMBER <i>D43235</i>	
29d. DATE SIGNED (Month, Day, Year) <i>10/12/94</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Elia Abboud M.D. Church Hospital</i>		31. DATE FILED (Month, Day, Year) <i>OCT 18 1994</i>	
32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30459

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian May Steiner				2. DATE OF DEATH MONTH 10 - DAY 15 - YEAR 94		3. TIME OF DEATH 2:50p M	
4. SOCIAL SECURITY NUMBER 219-14-9578		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) 8-14-1913	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 48 Shore Road				9b. CITY, TOWN OR LOCATION OF DEATH Edgemere		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Edgemere		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 48 Shore Road				10f. ZIP CODE 21219		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Clarence Fogle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Steiner			
19a. INFORMANT'S NAME (Type/Print) Mary V. May				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Shore Road Balto Md 21219			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Lewistown Cemetery 10-18-94		20c. LOCATION — City or Town, State Lewistown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William D. Berkey Jr.</i>				22. NAME AND ADDRESS OF FACILITY Robert E. Dailey and Son Funeral Home 615 E. Main St., Thurmont Md. 21788 P.A.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. GANGRENE OF LOWER EXTREMITIES DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non-INSULIN DEPENDENT DIABETES MELLITUS							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER 95014		29d. DATE SIGNED (Month, Day, Year) 10-17-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VAHAKN SHAHINIAN M.D. 4940 Eastern Ave Balto. Md 21224							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE <i>John Danison-Russell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-15-19

1-1-13

2151

10-15-19

1-1-13

1-1-13

1-1-13

94 30460

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARRY JAMES SMITH				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 84		3. TIME OF DEATH 4:45 P M	
4. SOCIAL SECURITY NUMBER 218-07-5886		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03/13/21	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1155 W. Hamburg Street				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-9th College (14 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) sheet metal worker		16b. KIND OF BUSINESS/INDUSTRY construction			
17. FATHER'S NAME (First, Middle, Last) Charles Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma V. Allen			
19a. INFORMANT'S NAME (Type/Print) Margaret J. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1155 W. Hamburg Street Baltimore, Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery		DATE 10/20/94		20c. LOCATION — City or Town, State Glen Burnie, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. anemia DUE TO (OR AS A CONSEQUENCE OF): c. pancreatic carcinoma DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 hr							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D02063		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KASZUBA ROBERT M.D. ST. AGNES HOSPITAL, BALTIMORE, MD, 21223							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5931-025

B.K.S

94 30461

ITEMS: 23 PART I, 27, PER MEO FILM G-717 11/22/94 t.t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BRIAN GLENN SWANN				2. DATE OF DEATH MONTH DAY YEAR OCT. 14 94		3. TIME OF DEATH 10:58 A M	
4. SOCIAL SECURITY NUMBER 219-39-2107		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 1 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 25, 1993	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL E.R.		9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON	
9c. COUNTY OF DEATH HARFORD				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Edgewood				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1900 Southridge Drive	
10f. ZIP CODE 21040				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Mexican		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (14 or 5+) n/a				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Louise Shanholtzer			
19a. INFORMANT'S NAME (Type/Print) Katherine L. Shanholtzer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Southridge Drive, Edgewood, Md. 21040			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 10/17/94 Aldino, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. EPENDYMOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Gole, Jr. MD</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 15, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. Gole, Jr. MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John F. Gole, Jr.</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30462

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ella G. Smith</i>				2. DATE OF DEATH MONTH DAY YEAR <i>October 15, 1994</i>		3. TIME OF DEATH <i>940P</i>	
4. SOCIAL SECURITY NUMBER 214-62-7060		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-26-56	
9a. FACILITY NAME (If not institution, give street and number) Southern MD. Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH MD.	
10a. STATE MD.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1432 Argyle Ave.			
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Justine Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Johnny Smith			
19a. INFORMANT'S NAME (Type/Print) Sylvia M. Fisher				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2863 W. Lanvale St. Baltimore, MD. 21216			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cem. 10-20-94 Lansdowne Md.		20c. LOCATION — City or Town, State		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H PA 638 N. Gilmore St. Baltimore, MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acquired immunodeficiency syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin dependent diabetes mellitus, chemical abuse, cachectic</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) <i>October 16, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>August P. Rodriguez MD, 5009 Rayburn Ct. Cy Spr. Md 20748</i>							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30463

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel Irene SVASEK				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 1994		3. TIME OF DEATH 12:00P M	
4. SOCIAL SECURITY NUMBER 216 20 6052		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-21-1924	
8. BIRTHPLACE (State or Foreign Country) W. Virginia		9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Essex		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Harford Co		10c. CITY, TOWN OR LOCATION Edgewood		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1000 A Magnolia Woods Lane				10f. ZIP CODE 21040		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) no		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN, Real Estates Sale		16b. KIND OF BUSINESS/INDUSTRY LPN/Federal Gov't			
17. FATHER'S NAME (First, Middle, Last) George W. Cornwell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Purcilla Hankins			
19a. INFORMANT'S NAME (Type/Print) David Campbell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000A Magnolia Woods La, Edgewood, MD 21040			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute respiratory acidosis DUE TO (OR AS A CONSEQUENCE OF): Hypoxia with hypercarbia DUE TO (OR AS A CONSEQUENCE OF): Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Severe chronic obstructive pulmonary disease							Approximate interval Between Onset and Death 8 hours 8 hours 6 days 10 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic cardiovascular disease, Hypertension Atrial fibrillation, Diabetes Mellitus Type II, Hypothyroidism							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Diane Ceruzzi DO				29c. LICENSE NUMBER n/a		29d. DATE SIGNED (Month, Day, Year) 10-12-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIANE CERUZZI D.O. 9000 FRANKLIN Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) OCT 18 1994		32. REGISTRAR'S SIGNATURE J. Buckner					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES MARIE Francis Marie Sabloski				2. DATE OF DEATH MONTH DAY YEAR 10 14 1994		3. TIME OF DEATH 1:13 A M	
4. SOCIAL SECURITY NUMBER 220-03-5717		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1919 MARCH 26,	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) 5 CHESTER CIRCLE		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5 CHESTER CIRCLE	
10f. ZIP CODE 21060				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOME MAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) WESLEY WALDEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) JANE SUSAN KALLUM			
19a. INFORMANT'S NAME (Type/Print) RONALD ADAM SABLowski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 93556 39750 EADMER AVE, PALMDALE, CALIFORNIA			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PK 10/17/94			
20c. LOCATION — City or Town, State GLEN BURNIE, MD.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Henry Dykstra</i>			
22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
24. Approximate Interval Between Onset and Death 1mth				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 10/14/94			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Henry Dykstra</i>				29c. LICENSE NUMBER D26307			
29d. DATE SIGNED (Month, Day, Year) 10/14/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4000 ANNAPOLIS Rd. Baltimore MD 21227			
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30465

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William J. Temple</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>14</i> YEAR <i>94</i>		3. TIME OF DEATH <i>0335</i> M	
4. SOCIAL SECURITY NUMBER <i>220054674</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>July 18, 1919</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		8c. COUNTY OF DEATH <i>Maryland</i>	
9a. STATE <i>Maryland</i>				9b. COUNTY <i>Baltimore</i>		9c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10a. STREET AND NUMBER <i>2605 Eastern Avenue</i>				10b. ZIP CODE <i>21224</i>		10c. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Machine Operator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Factory</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Unknown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Agnes Unknown</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mary Ruth Temple</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2605 Eastern Avenue Baltimore, Maryland 21224</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Veterans</i>		20c. DATE <i>10/17</i>		20d. LOCATION — City or Town, State <i>Owings Mills, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. Weber</i>				22. NAME AND ADDRESS OF FACILITY <i>David J. Weber Funeral Home 21231 401 S. Chester Street Baltimore, Maryland</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>End stage COPD</i> Approximate interval between Onset and Death <i>many years</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David J. Weber M.D. - Specialist</i>		29c. LICENSE NUMBER <i>D40356</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/14/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>UNAVAPRO 100 N. Broadway, Balb. MD. 21231</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 18 1994</i>		32. REGISTRAR'S SIGNATURE <i>John Benson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

94 30466

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA WEEDON				2. DATE OF DEATH MONTH 10 DAY 17 YEAR 94		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 212-09-4732		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-11-00	
9a. FACILITY NAME (If not institution, give street and number) FREDERICK VILLA NSG. CTR				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 802 Woodsdale Avenue				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8th College (1-4 or 5+) clerk				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk		16b. KIND OF BUSINESS/INDUSTRY retail slaes	
17. FATHER'S NAME (First, Middle, Last) Alylouis P. Spindler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Nues			
19a. INFORMANT'S NAME (Type/Print) Joan D. McIntyre				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Woodsdale Road Catonsville, Md. 21228			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 10/19/94 Baltimore, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
b. Alzheimer's type dementia DUE TO (OR AS A CONSEQUENCE OF):							
c. anorexia DUE TO (OR AS A CONSEQUENCE OF):							
d. atherosclerotic disease DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 29769		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Marcelino D. Alvarez 5160 Rolling Rd Cat 21228							
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

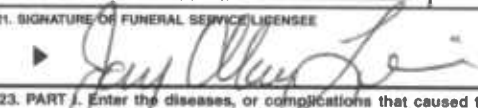
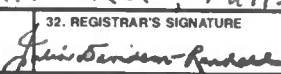
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30467

ITEM: 19b, PER F.H. FILM G-716 10/18/94 t.t

1 -
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Tanya Zabarskaya				2. DATE OF DEATH MONTH Oct DAY 13 YEAR 1994				3. TIME OF DEATH 5:23 P M	
4. SOCIAL SECURITY NUMBER 265-93-5830		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-21-1912		8. BIRTHPLACE (State or Foreign Country) RUSSIA	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3606 ANNE HATHAWAY DR. APT. 1-B				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) LEO HONDROS				18. MOTHER'S NAME (First, Middle, Maiden Surname) SONYA HONDROS					
19a. INFORMANT'S NAME (Type/Print) MRS. TAMARA VAVULITSKY				19b. MAILING ADDRESS (Street and Number or Rural Route 3-D State, Zip Code) 3606 ANNE HATHAWAY DR, APT 1-B, RANDALLSTOWN, MD 21133					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW		DATE 10-16-94		20c. LOCATION — City or Town, State REISTERSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. 6010 Reisterstown Rd, Baltimore, MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequently flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Severe Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Heart Failure DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 2 minutes 5 years 5 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Peripheral Vascular Disease								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Peter J. Golueke M.D.				29c. LICENSE NUMBER D25349		29d. DATE SIGNED (Month, Day, Year) 10/14/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2112 Belair Rd, Fallston, Md. 21047									
31. DATE FILED (Month, Day, Year) OCT 18 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30468

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR HENRY BANKS				2. DATE OF DEATH MONTH 10 DAY 18 YEAR 94		3. TIME OF DEATH 1:48 A M	
4. SOCIAL SECURITY NUMBER 107-32-4777		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1921	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Perry Hall		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11 Chatterly Court				10f. ZIP CODE 21128		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping Clerk		16b. KIND OF BUSINESS/INDUSTRY P.H. Volk Shoe Co.			
17. FATHER'S NAME (First, Middle, Last) Henry Banks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary McGloin			
19a. INFORMANT'S NAME (Type/Print) Rosemary P. Seager (niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Chatterly Court, Perry Hall, MD 21128			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Joseph's Cemetery		DATE 10/21		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC CANCER							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner				29c. LICENSE NUMBER 225643		29d. DATE SIGNED (Month, Day, Year) 10/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL R. FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-5898-510

L.R.B.

item 18, g-716, 10-19-94, per F.H., dr

94 30469

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) CLARENCE E. BASS			2. DATE OF DEATH MONTH DAY YEAR OCT 13 1994		3. TIME OF DEATH 7:48P
4. SOCIAL SECURITY NUMBER 213-76-5205	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 28 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec 13, 1965	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U.			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.		9c. COUNTY OF DEATH
10a. STATE Maryland			10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER 1510 North Appleton Street		
10f. ZIP CODE 21217			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Gold L. Bass, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Clarice Pate Patterson		
19a. INFORMANT'S NAME (Type/Print) Clarice Bass			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 Woodgreen Circle Baltimore, MD 21207		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 10/19 Baltimore County, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Horn Parker</i>			22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gunshot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10/13/94		28b. TIME OF INJURY 1910 hrs	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED subject shot		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 500 Black Mount Street	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 14 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201.					
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE <i>Johnston-Parker</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a death certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2501 Gwynns Falls Parkway
Baltimore, Maryland 21216

94 30470

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADRIENNE BROGDEN				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 18 1994		3. TIME OF DEATH 9:55A	
4. SOCIAL SECURITY NUMBER 220-14-4542		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 13, 1913	
9a. FACILITY NAME (If not institution, give street and number) Keswick Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 520 Sanford Place				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Rufus Gardner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Gardner			
19a. INFORMANT'S NAME (Type/Print) Gladyce Gardner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1190 West Northern Parkway			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Omeco Crematory		DATE 10/19		20c. LOCATION — City or Town, State Catonsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dementia diagnosed as Alzheimer's disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 5-6 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Isabelle MacGregor M.D.				29c. LICENSE NUMBER D13657		29d. DATE SIGNED (Month, Day, Year) October 18, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. ISABELLE MACGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE John S. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2



3



94 30471

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT E. BOONE JR.				2. DATE OF DEATH MONTH DAY YEAR 10-14-94		3. TIME OF DEATH HOUR MIN. 1230 P M	
4. SOCIAL SECURITY NUMBER 141-32-4454		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/27/42	
9a. FACILITY NAME (If not institution, give street and number) Springfield Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Sykesville		9c. COUNTY OF DEATH Carroll	
10a. STATE md		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Sykesville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Hitchmen Building				10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown		16b. KIND OF BUSINESS/INDUSTRY Social Security Admin			
17. FATHER'S NAME (First, Middle, Last) Robert E. Boone Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Geneva B. Robinson			
19a. INFORMANT'S NAME (Type/Print) Denise Mitchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Cherrycrest Rd Apt E Balto, md 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. LOCATION — City or Town, State Landsdowne, md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Glynn B. Scott				22. NAME AND ADDRESS OF FACILITY March F H-west 4300 Wabash Ave			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPHYXIA (CHOKED ON FOOD) DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HUNTINGTON CHOREA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel J. Welliver M.D.				29c. LICENSE NUMBER D11496		29d. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL J. WELLIVER MD 912 WASHINGTON ROAD WESTMINSTER MD 21157							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30472

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY Barnes		2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 2043 M	
4. SOCIAL SECURITY NUMBER 214-68-4522		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 11-28-43		8. BIRTHPLACE (State or Foreign Country) N.C.			
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH	
10a. STATE md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2648 Park Heights Terrace		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2 yrs	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Hyatt Regency Hotel		17. FATHER'S NAME (First, Middle, Last) Milton James Barnes	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Beatrice Williams		19a. INFORMANT'S NAME (Type/Print) Grace Barnes		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2654 Park Heights Terrace Balto, md 21215	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 10/18/94		20c. LOCATION — City or Town, State Randallstown, md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Elson		22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Cardiac Arrhythmia (defibrillator) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Aortic Valve replacement twice (Rheum Fever) b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Carole Lee MD	
29c. LICENSE NUMBER D27075		29d. DATE SIGNED (Month, Day, Year) 10/18/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 102195. Duffield Rd. ONTARIO, MD 21117 E. LEVIN	
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE John Harrison-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020


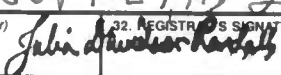
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30473

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER BROADNAX III			2. DATE OF DEATH MONTH DAY YEAR OCTOBER 15, 1994		3. TIME OF DEATH n/a
4. SOCIAL SECURITY NUMBER 218-62-7424	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 30 YRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. 8, 1964	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 1651 N. Bentalou Street			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A
10a. STATE MD			10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER 1651 N. Bentalou Street		
10f. ZIP CODE 21216			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A			
16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		17. KING OF BUSINESS/INDUSTRY Maryland Cup			
17. FATHER'S NAME (First, Middle, Last) Walter Broadnax, Jr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Inez Matthews		
19a. INFORMANT'S NAME (Type/Print) Walter Broadnax & Inez Matthews			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1651 N. Bentalou Street/Baltimore, MD 21216		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL GARDENS 10-21		20c. LOCATION — City or Town, State RANDALLSTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVE./BALTIMORE, MD 21202		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune deficiency syndrome DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Nisha Soprey MD		29c. LICENSE NUMBER D24476		29d. DATE SIGNED (Month, Day, Year) Oct. 18, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NISHA SOPREY MD 2300 Garrison Blvd Balto MD 21216					
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30474

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret M. Boney				2. DATE OF DEATH MONTH DAY YEAR October 14, 1994				3. TIME OF DEATH 2:46 P.M.	
4. SOCIAL SECURITY NUMBER 171-01-3729		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. FACILITY NAME (If not institution, give street and number) 503 A Red Pump Road				7b. CITY, TOWN OR LOCATION OF DEATH Bel Air				7c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 503 A Red Pump Road				10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Eugene Pavone				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Raymond					
19a. INFORMANT'S NAME (Type/Print) Loretta Hammen (daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 George Avenue, Baltimore, MD 21221					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 10/18		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metabolic lung CA</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 6440580		29d. DATE SIGNED (Month, Day, Year) 10/17/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Stephen G. Smaldore, 2021 Emmorton Rd., Suite 114, Bel Air, MD 21015									
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30475

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERBERT BRANDFORD				2. DATE OF DEATH MONTH 10 DAY 08 YEAR 84		3. TIME OF DEATH 8:23 P.M.	
4. SOCIAL SECURITY NUMBER 218-26-8524		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/27/31	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH MD	
10a. STATE MD				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 897 W. LOMBARD ST.			
10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED		16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION			
17. FATHER'S NAME (First, Middle, Last) JOSEPH BRANDFORD				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTIE BRANDFORD			
19a. INFORMANT'S NAME (Type/Print) JANIE MAE BRANDFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 897 W. LOMBARD ST. BALTIMORE MD 21201			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. LOCATION — City or Town, State 10/13/94 GLEN BURNIE MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): pneumonia DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D-45186		29d. DATE SIGNED (Month, Day, Year) 10/8/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. RACHOCKA 800 Catons Ave Balto MD 21228							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MITL

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROOSEVETT				2. DATE OF DEATH MONTH OCT DAY 13 YEAR 94				3. TIME OF DEATH 4:48 P.M.					
4. SOCIAL SECURITY NUMBER 228-20-5657		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 12/30/23		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) EDMONDSON & WHITMORE AVE						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY						9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY				10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2646 W. FRANKLIN ST.						10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED				16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION					
17. FATHER'S NAME (First, Middle, Last) WILLIAM H. BRODIE						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA BRODIE							
19a. INFORMANT'S NAME (Type/Print) CHARLOTTE BRODIE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2646 W. FRANKLIN ST. BALTIMORE MD 21223							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK				DATE 10/20/94		20c. LOCATION — City or Town, State BALTO. MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217							
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Injuries a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 10/13/94		28b. TIME OF INJURY 1632 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED motor vehicle Subject involved in accident			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 14, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30477

ITEM: 18. PER INFORMANT FILM G-717 11/1/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN S. BROWN				2. DATE OF DEATH MONTH 10 DAY 18 YEAR 1994		3. TIME OF DEATH 6:45 AM	
4. SOCIAL SECURITY NUMBER 214-40-5736		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-16-01	
8a. FACILITY NAME (If not institution, give street and number) CHURCH HOME				8b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY		8c. COUNTY OF DEATH	
9a. RESIDENCE OF DECEDENT 10a. STATE MD.				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTO. CITY	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 101 NO. BOND ST.		10f. ZIP CODE 21231	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ YEARS	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SOCIAL WORKER				16b. KIND OF BUSINESS/INDUSTRY CITY OF BALTIMORE		17. FATHER'S NAME (First, Middle, Last) JOHN RUFF STREETT	
18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA BALDWIN HANNAH BALDWIN				19a. INFORMANT'S NAME (Type/Print) ALEXANDER P. BROWN, III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6108 BUCKINGHAM MANOR DR., BALTO. MD. 21210	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CHRIST CH. OF ROCK SPRING		20c. LOCATION — City or Town, State FOREST HILL, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. H. Ruff				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER A. F. Norzemi M.D.				29c. LICENSE NUMBER D17322		29d. DATE SIGNED (Month, Day, Year) 10/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. F. NORZEMI M.D., 101 NORTH BOND STREET, BALTIMORE, MD. 21231							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE John Benbow-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

102.

1

94-5942-510
L.R.B.

94 30478

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARDELL				BLACKWELL				2. DATE OF DEATH OCT 15 DAY 1994 YEAR		3. TIME OF DEATH 7:18P	
4. SOCIAL SECURITY NUMBER 215-40-7346		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 4-1994		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 1401 N. LAKEWOOD AVE.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.				9c. COUNTY OF DEATH NONE			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1401 N. LAKEWOOD AVE. APT. 407				10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X				14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) NONE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION WORKER				16b. KIND OF BUSINESS/INDUSTRY DIFFERENT COMPANIES			
17. FATHER'S NAME (First, Middle, Last) DETROY BLACKWELL				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH BROOKS							
19a. INFORMANT'S NAME (Type/Print) JUANITA JENKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 INGRAM RD. BALTO, MD. 21239							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 10/20/94				20c. LOCATION — City or Town, State BALTO, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i>				22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> <i>inspection</i>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 16 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Theodore M. King</i> 111 Penn Street, Baltimore, Maryland 21201.											
31. DATE FILED (Month, Day, Year) OCT 19 1994						32. REGISTRAR'S SIGNATURE <i>John Harrison Riddle</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30479

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Alvin Brown</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>17</u> YEAR <u>94</u>		3. TIME OF DEATH <u>2:25 A</u> M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>47</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>01 28 47</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Bay View Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD.</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6612 Woods Parkway</u>				10f. ZIP CODE <u>21221</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Truck Driver</u>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <u>Alvin Brown Sr.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Sallie Spain</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Kenneth Judd</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6612 Woods Parkway Balto., MD. 21221</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory 10/94</u>		20c. LOCATION — City or Town, State <u>Balto., MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Dorothy Hector</u> CFSP #281				22. NAME AND ADDRESS OF FACILITY <u>1721-27 N. Monroe ST. E.L. Phillips F/H Balto., MD. 21217</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Tuberculosis</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>AIDS (Acquired Immuno-deficiency Syndrome)</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>wasting syndrome</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>CV Plowe ID Fellow</u>				29c. LICENSE NUMBER <u>N4173448</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/17/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>CV Plowe MD Johns Hopkins Hospital Room 1159 Baltimore MD</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 19 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Smith-Rodriguez</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30480

Items 1, 7&9b, g-716, 10-19-94, per F.H., dr

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Betty Belman</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>16</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1238p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>215 54 0829</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH <i>01-08-1918</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Betho. Md. Randallstown</i>		9c. COUNTY OF DEATH <i>Balto</i>	
10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>4001 CLARKS LANE, APT. 501</i>				10f. ZIP CODE <i>21215</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>AT HOME</i>			
17. FATHER'S NAME (First, Middle, Last) <i>BENJAMIN MALIN</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>IDA</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MR. HARRIS BELMAN</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9700 HIDDEN VALLEY ROAD VIENNA, VA 22181</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>AGUDAS BNAI JACOB LODGE 10-18-94 ROSEDALE, MD</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>UGI bleed</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>peptic ulcer</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <i>hours</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>myeloproliferative disease</i> <i>ischemic heart disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Brian S. Skantvoff</i>				29c. LICENSE NUMBER <i>D19261</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/17/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>10085 Red Run Blvd Annapolis, MD 21417 BRIAN S. SKANTVOFF MD</i>							
31. DATE FILED (Month, Day, Year) <i>00119 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0626
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30481

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA BRYAN				2. DATE OF DEATH MONTH 10 DAY 12 YEAR 94		3. TIME OF DEATH 11:25 A M	
4. SOCIAL SECURITY NUMBER 215-30-4230		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-19-1935	
8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA				9. FACILITY NAME (If not institution, give street and number) BON SECOUR HOSPITAL		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
11. RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1605 W. LEXINGTON STREET		10f. ZIP CODE 21223	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) EARLENE WRIGHT			
19a. INFORMANT'S NAME (Type/Print) CAROLYN WRIGHT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 BRADDISH AVE, BALTO. MD 21216			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT ZION CEMETERY 10-18-94 BALTIMORE, MD		20c. LOCATION — City or Town, State		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carol P. Brown</i>	
22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTO. MD. 21223				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → sepsis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Status Post Endotracheal Intubation b. DUE TO (OR AS A CONSEQUENCE OF): Respiratory Distress and Failure c. DUE TO (OR AS A CONSEQUENCE OF): Aspiration Pneumonia d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure, Active Pulmonary TB, Thrombophlebitis and Pneumomediastinum				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Janet V. Mochel, M.D.				29c. LICENSE NUMBER D14949		29d. DATE SIGNED (Month, Day, Year) OCT 19 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JANET V. MOCHHEL, M.D. BON SECOUR HOSPITAL, 2000 W. BALTO ST MD 21223							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If illness was marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-30482

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA M. BEATT				2. DATE OF DEATH MONTH DAY YEAR Oct. 17 1994				3. TIME OF DEATH 9:00 PM	
4. SOCIAL SECURITY NUMBER 220-14-9015		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) Mar. 18, 1918		8. BIRTHPLACE (State or Foreign Country) Mass.			
9a. FACILITY NAME (If not institution, give street and number) 2703 Fallsmont Drive				9b. CITY, TOWN OR LOCATION OF DEATH Fallston			9c. COUNTY OF DEATH Harford		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11202 Bird River Grove Rd.				10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (14 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector			16b. KIND OF BUSINESS/INDUSTRY Westinghouse			
17. FATHER'S NAME (First, Middle, Last) Alexander Czebotar				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophia Aleskafida					
19a. INFORMANT'S NAME (Type/Print) Mrs. Joan Bridges				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Fallsmont Drive Fallston, Md. 21047					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 10-20-94			20c. LOCATION — City or Town, State Baltimore, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. LUNG Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 3 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIA								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NIA		28b. TIME OF INJURY NIA M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED NIA	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NIA				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NIA			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Walker MD</i> Internist				29c. LICENSE NUMBER D 37239		29d. DATE SIGNED (Month, Day, Year) 10/18/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1447 York Rd. Suite # 100 21093 (339-5500)									
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HUSBAND OF THE DECEASED: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30483

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM F. BELL William Bell				2. DATE OF DEATH 10-9-94 MONTH DAY YEAR		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-32-0006		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/23/35	
9a. FACILITY NAME (If not institution, give street and number) Dor. General Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 309 Choptank Ave.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES National Guard 345		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) general laborer				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) general laborer		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William Fredrick Bell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda Lee North			
19a. INFORMANT'S NAME (Type/Print) Robert Trigger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Choptank Ave Cambridge MD 21613			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) State Anatomy Board		20c. LOCATION — City or Town, State Baltimore, MD		20d. DATE 10/9/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Peripheral Vascular disease SMOKER							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Hubert J. Feery			
29c. LICENSE NUMBER D22773				29d. DATE SIGNED (Month, Day, Year) 10/13/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print) HUBERT FEERY MD				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print) 503 BYRNST CAMBRIDGE MD 21613			
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE Hubert Feery			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30484

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lucille Clarke</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>18</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1:06 a m</i>	
4. SOCIAL SECURITY NUMBER <i>213-01-9700</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7/28/1920</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Hopkins Bayview Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>3438 Dunran Rd.</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Flower Arranger</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Dundalk Florist</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Stanislaus Byczynski</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Valerie Pukalski</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Murray Clarke</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1745 Stokesley Rd. Dundalk Md. 21222</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Balto. National</i>		DATE <i>10/21</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Colt Connolly</i>				22. NAME AND ADDRESS OF FACILITY <i>Connolly Funeral Home of Dundalk 7110 Sollers Pt. Rd. Dundalk 21222</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James P. Farnell MD</i>				29c. LICENSE NUMBER <i>94014</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/18/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JBMC 4840 Eastern Ave Baltimore MD 21223</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 19 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


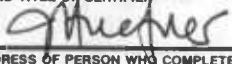
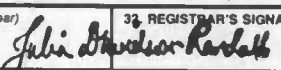
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30485

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annette M. Coster				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 11:14 AM	
4. SOCIAL SECURITY NUMBER 219-16-6356		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH ---				10a. STATE Maryland		10b. COUNTY ---	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 325 South Bouldin Street	
10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Frederick H. Bahr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary C. Smith			
19a. INFORMANT'S NAME (Type/Print) Dennis H. Coster (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Twig Court, White Hall, Md. 21161			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. LOCATION — City or Town, State 10/20 Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery disease DUE TO (OR AS A CONSEQUENCE OF): b. Peripheral vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death years years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 120 S. Greene Street Baltimore MD 21201							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ADJUTANT

100

100

100

94 30486

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Vernon Clark Jr</u>				2. DATE OF DEATH MONTH <u>Oct</u> DAY <u>13</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>11:18 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>216-36-843</u>		5. SEX <u>M</u> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>53</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>March 5, 1941</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Baltimore, MD</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Sinai Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore, MD</u>	
9c. COUNTY OF DEATH <u>Baltimore City</u>				10a. STATE <u>MD.</u>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>2619 W. BELVERDERE AVE. APT. 1 C</u>			
10f. ZIP CODE <u>21215</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>AFR. AMERICAN</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>DISABILITY</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>VERNON L. CLARK SR.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LILLIE M. CLARK</u>			
19a. INFORMANT'S NAME (Type/Print) <u>LILLIE M. CLARK</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2619 W. BELVERDERE AVE. BALTO. MD. 21215</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>WESTERN STAR 10/19/94</u>		20c. LOCATION — City or Town, State <u>CATONSVILLE, MD.</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Carl A. Estep</u>	
22. NAME AND ADDRESS OF FACILITY <u>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217</u>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Ventricular Fibrillation</u> DUE TO (OR AS A CONSEQUENCE OF): <u>as result of massive cerebral hemorrhage</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>c. HIV Infection</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <u>5 min</u> <u>24 hrs</u> <u>> 1 yr</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Vincent Lee MD</u>				29c. LICENSE NUMBER <u>VL9833</u>		29d. DATE SIGNED (Month, Day, Year) <u>Oct 13, 1994</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Vincent Lee / Sinai Hospital 2401 W. Belvedere Ave Baltimore MD 21215</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 19 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Benson-Kendall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30487

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELEANOR W. CANTER				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 900 P.M.	
4. SOCIAL SECURITY NUMBER 216-52-5342		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-26-1917	
9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION TOWSON	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2300 DULANEY VALLEY RD.				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE		16b. KIND OF BUSINESS/INDUSTRY MEDICAL			
17. FATHER'S NAME (First, Middle, Last) ALLEN WARFIELD				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA BAMBER			
19a. INFORMANT'S NAME (Type/Print) ANN C. WILES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20717 KEENEY MILL RD. FREELAND, MD. 21053.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GARDENS		20c. LOCATION — City or Town, State COCKEYSVILLE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE William K. Davis III				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. BRAIN Tumor DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D 15504		29d. DATE SIGNED (Month, Day, Year) 10-15-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. Nakhuda M.D., 2300 DulaneY Valley Road, Towson 21204							
31. DATE FILED (Month, Day, Year) OCT 19 1994							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.


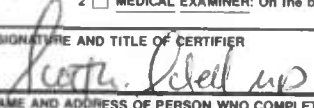

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30488

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EAN HONG HENG - CHUNG				2. DATE OF DEATH OCTOBER 14, 1994		3. TIME OF DEATH 4:10 a. M		
4. SOCIAL SECURITY NUMBER NONE		5. SEX XX M 2 <input type="checkbox"/> F	8. AGE (In yrs. last birthday) 19 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-14-75		8. BIRTHPLACE (State or Foreign Country) SINGAPORE	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT								
10a. STATE REPUBLIC		10b. COUNTY OF SINGAPORE		10c. CITY, TOWN OR LOCATION SINGAPORE		10d. INSIDE CITY LIMITS? XX YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 28 LEONIE HILL				10f. ZIP CODE 0923		10g. CITIZEN OF WHAT COUNTRY? SINGAPORE		
11. MARITAL STATUS XX Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES XX NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CHINESE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 YEAR		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT		16b. KIND OF BUSINESS/INDUSTRY COLLEGE				
17. FATHER'S NAME (First, Middle, Last) EDWARD H. K. HONG				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIN Y. KHOO				
19a. INFORMANT'S NAME (Type/Print) KOCH FUNERAL HOME				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 S.ATHETON ST., STATE COLLEGE, PA. 16801				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation XX Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAKWOOD CREMATORY 10-19		DATE 10-19		20c. LOCATION — City or Town, State STATE COLLEGE, PA.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Perineal GAS gangrene DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Sepsis / Pneumobiosis coli DUE TO (OR AS A CONSEQUENCE OF): c. neutropenia DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 2 days 2 days 2 weeks								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatic / Renal Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED						
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER  Scott R. Shelby MD				29c. LICENSE NUMBER D44356		29d. DATE SIGNED (Month, Day, Year) 10/14/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Scott R. Shelby MD Johns Hopkins Hospital								
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30489

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WESLEY LEROY COATES				2. DATE OF DEATH MONTH 10 DAY 13 YEAR 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 216-01-2495		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-24-1917	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 302 MT. HOLLY		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 302 MT. HOLLY	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE RIGGING COMPANY	
17. FATHER'S NAME (First, Middle, Last) NATHANIEL COATES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL RICE			
19a. INFORMANT'S NAME (Type/Print) EULA COATES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 MT. HOLLY, BALTIMORE, MARYLAND 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS CEMETERY		20c. LOCATION — City or Town, State 10-19-94 ARBUTUS, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CANCER of Lung Cachexia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Due to (or as a consequence of): Heart Failure c. Due to (or as a consequence of): As CVD d. Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 107837		29d. DATE SIGNED (Month, Day, Year) 10-13-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hiromi Nakagawa was 3350 Wilkens Ave Balt 21229							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

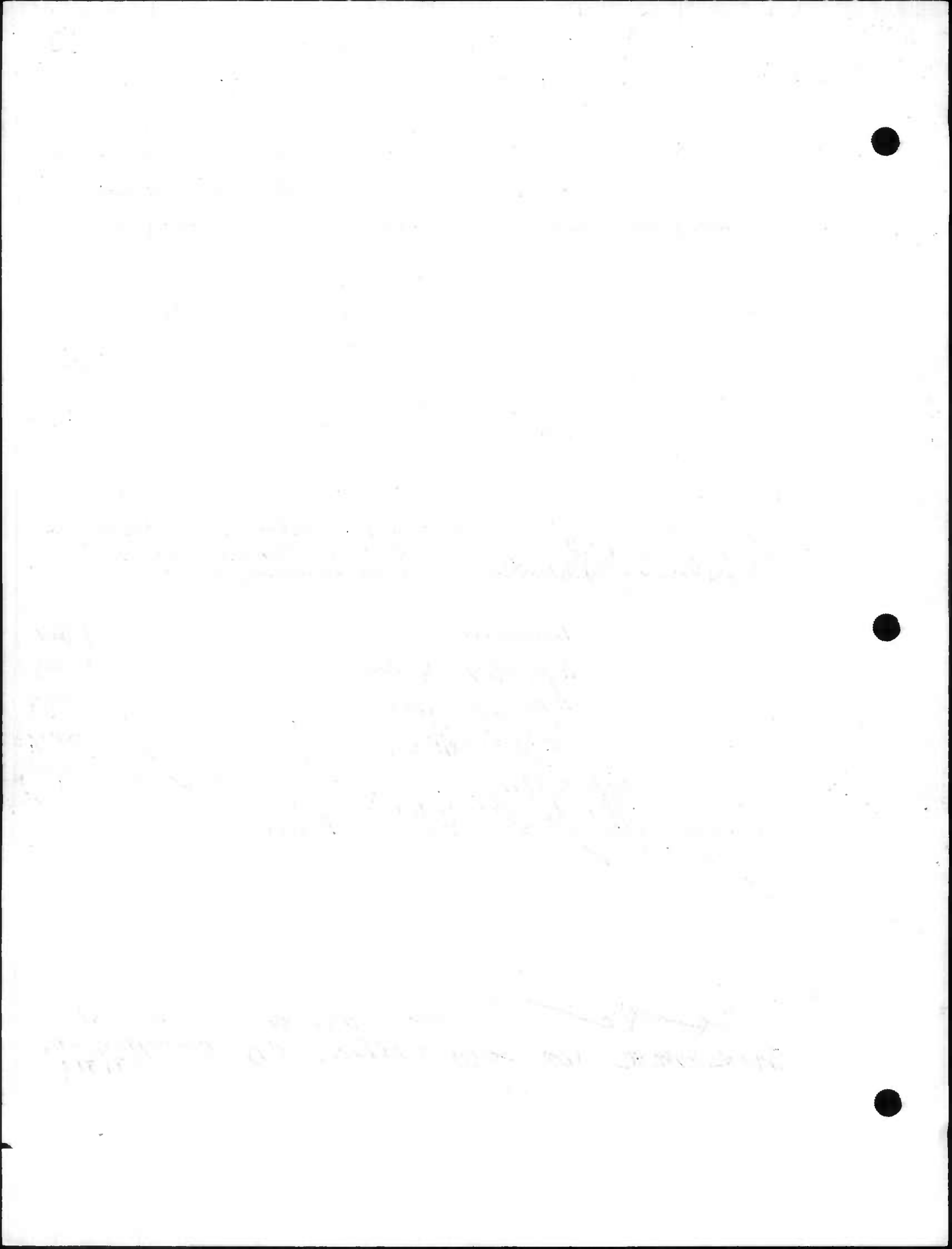
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond Willard Creek, Sr.				2. DATE OF DEATH MONTH DAY YEAR October 11 1994				3. TIME OF DEATH 0220 A M							
4. SOCIAL SECURITY NUMBER 219-03-8066		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 09/26/1897		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown						9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Little Orleans				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER Rt.1 Box 137						10f. ZIP CODE 21766				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				18b. KIND OF BUSINESS/INDUSTRY Allegany County Roads Dept.							
17. FATHER'S NAME (First, Middle, Last) Alfred Creek						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Brady									
19a. INFORMANT'S NAME (Type/Print) Hazel M. Souders				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Maryland Avenue Hancock, MD. 21750											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Piney Plains U.M. Cemetery 10/14/94 Little Orleans, MD. 21766				20c. LOCATION — City or Town, State Grove Funeral Home 141 W. Main Street P.O. Box 368 Hancock, MD. 21750							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home 141 W. Main Street P.O. Box 368 Hancock, MD. 21750											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Respiratory Failure Hypertension Dehydration												Approximate Interval Between Onset and Death 1 DAY 10 HRS. 10 HRS. 1 DAY			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression Senile Dementia												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined							
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D44996				29d. DATE SIGNED (Month, Day, Year) 10-11-94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZAFAR MAJID MD 20311 LAPPAN'S RD BOONSBORO MD 21713															
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											



94 30491

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VICTORIA CIEMNY				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94				3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 220-14-7078		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 7, 1902		8. BIRTHPLACE (State or Foreign Country) Balto. Md.		
9a. FACILITY NAME (If not institution, give street and number) Citizen Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace				9c. COUNTY OF DEATH Harford		
10a. STATE Maryland			10b. COUNTY Harford			10c. CITY, TOWN OR LOCATION Bel Air			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1610 S. Tolgate Road				10f. ZIP CODE 21015				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress				16b. KIND OF BUSINESS/INDUSTRY Lion Brothers		
17. FATHER'S NAME (First, Middle, Last) Joseph Cymbor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maryanna Tyszkiewicz						
19a. INFORMANT'S NAME (Type/Print) Mrs. Rita C. Handy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 S. Tolgate Rd. BelAir, Md. 21015						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Most Holly Redeemer Cem. 10/20/94				20c. LOCATION — City or Town, State Baltimore, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE E.F. Lassahn Funeral Home				22. NAME AND ADDRESS OF FACILITY E.F. LASSAHN FUNERAL HOME 11750 BELAIR RD KINGSVILLE, MD. 21087						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										
a. Generalized Arterial Occlusion of Lower Extremities										
DUE TO (OR AS A CONSEQUENCE OF):										
b. Peripheral Vascular Disease										
DUE TO (OR AS A CONSEQUENCE OF):										
c.										
DUE TO (OR AS A CONSEQUENCE OF):										
d.										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Cerebral Artery Disease										
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED						
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D19J83				29d. DATE SIGNED (Month, Day, Year) 10/17/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LATA, MANUEL 8 Law St. - Aberdeen, AR 72001										
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE John Sanders-Russell						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30492

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA CYRAN				2. DATE OF DEATH MONTH 10 DAY 15 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 220-09-0822		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-9-03	
9a. FACILITY NAME (If not institution, give street and number) RIVER VIEW NURSING HOME / HOPKINS BAYVIEW				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH MARYLAND	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RIVER VIEW NURSING HOME				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YEARS		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) VALENTINE PHILLIPS				16. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) MRS. DOLORES SEEBACHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 CROSS POINTE CT. 1C ABINGDON, MD. 21009			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) OAKLAWN CEM		DATE 10-18		20c. LOCATION — City or Town, State BALTO CO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczorowski</i>				22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>bowel perforation</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death <i>4dys</i> <i>4dys</i> <i>75yrs</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) <i>10-11-94</i>		28b. TIME OF INJURY <i>AM</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Secondary to debility + impact</i>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>hospital enr HO</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Bayview Hospital</i>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. Dike, MD</i>				29c. LICENSE NUMBER <i>95005</i> <i>AF 2664200-DS7</i>		29d. DATE SIGNED (Month, Day, Year) <i>10-15-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>G. Dike, MD, Johns Hopkins Bayview, Int. Med Dept, Balto, MD</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 19 1994</i>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30493

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES T CLIFFORD				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1994		3. TIME OF DEATH 9:25PM M	
4. SOCIAL SECURITY NUMBER 212 18 8745		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-30-1918	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Med Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore Co		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1010 Kenilworth Drive				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Adm Assistant		16b. KIND OF BUSINESS/INDUSTRY Circuit Court			
17. FATHER'S NAME (First, Middle, Last) George Rooney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen O'Brien			
19a. INFORMANT'S NAME (Type/Print) Judy H. Ring-Cohen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1498 Palisades Dr, Pacific Palisades, CA 90272			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ruptured femoral artery</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>acute renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>acute myocardial infarction</i>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <i>aspiration pneumonia</i> <i>Wt 1 bleed.</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bruce Rosenberg</i>				29c. LICENSE NUMBER D24121		29d. DATE SIGNED (Month, Day, Year) 10/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE ROSENBERG 1134 YORK RD LUTHERVILLE, MD 21093							
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30494

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA Vennessa CUNNINGHAM				2. DATE OF DEATH MONTH DAY YEAR October 9, 1994		3. TIME OF DEATH 10:55 A M	
4. SOCIAL SECURITY NUMBER 212-01-9637		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-6-1908	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE Maryland				10b. COUNTY Allegany Co		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 815 Columbia Avenue			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Walter Herbert Stevens				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Pearl Yantz			
19a. INFORMANT'S NAME (Type/Print) Jacquelyn Wolfe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 White Avenue, Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Subendocardial Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sublethal Hematoma secondary to fall</i> <i>Recurrent peptic ulcer</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Barrera</i>				29c. LICENSE NUMBER D14865		29d. DATE SIGNED (Month, Day, Year) 10-9-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Barrera Memorial Hospital Medical Building Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LESLIE H. DRUMMOND				2. DATE OF DEATH MONTH DAY YEAR OCT 15 94		3. TIME OF DEATH 8:21 P.M.	
4. SOCIAL SECURITY NUMBER 216-86-7263		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 20 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-20-74	
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY S.T.U.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH MD	
10a. STATE MD				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTO	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3305 CARDENAS AVE		10f. ZIP CODE 21213	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) LESLIE H. DRUMMOND SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LORETTA LANGLEY			
19a. INFORMANT'S NAME (Type/Print) LORETTA LANGLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 CARDENAS AVE BALTO, MD 21213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD NATIONAL MEM PK. 102094 LAUREL, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF NECK WITH COMPLICATIONS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) OCT 10, 1994		28b. TIME OF INJURY 9:20P	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED SUBJECT SHOT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 700 BLK.N.CAREY STREET			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golve, Jr.</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 16, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLVE, JR. MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>GRACE DAVIS Grace Elizabeth Davis</u>				2. DATE OF DEATH MONTH <u>OCTOBER</u> DAY <u>15</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>10:04 P</u> M	
4. SOCIAL SECURITY NUMBER <u>213-078943B</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>3-15-1914</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>THE JOHNS HOPKINS HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>		9c. COUNTY OF DEATH <u>VA.</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>BALT</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1115 N. KENWOOD AVE</u>				10f. ZIP CODE <u>21213</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>13</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOUSE-WIFE</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>WALTER HAYES</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ESTELLA ALLEN</u>			
19a. INFORMANT'S NAME (Type/Print) <u>BARBARA McLEOD</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1115 N. KENWOOD AVE BALT. MD 21213</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>BALTIMORE CEM.</u>		DATE <u>10/20</u>		20c. LOCATION — City or Town, State <u>BALT CITY</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Patricia Betts</u>				22. NAME AND ADDRESS OF FACILITY <u>BETTS FUNERAL HOME BALD. MD 21213</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Subarachnoid hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): <u>middle cerebral artery aneurysm</u> DUE TO (OR AS A CONSEQUENCE OF): <u></u> DUE TO (OR AS A CONSEQUENCE OF): <u></u> DUE TO (OR AS A CONSEQUENCE OF): <u></u>						Approximate interval Between Onset and Death <u>2 days</u> <u>4 months</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hypertension, diabetes mellitus</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Jeremy Rich MD</u>				29c. LICENSE NUMBER <u>L-9754</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/15/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Jeremy Rich MD - Johns Hopkins Hospital, Pathology 509, Baltimore MD 21209</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 19 1994</u> <u>John D. Harrison</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30497

Item 17, g-716, 10-19-94, per F.H., dr

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RIVA DRUYAN				2. DATE OF DEATH MONTH DAY YEAR October 15 1994		3. TIME OF DEATH 11:30pm M	
4. SOCIAL SECURITY NUMBER 216-92-4976		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 25, 1908	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2926 TANEY ROAD, APT. 2B				10f. ZIP CODE 21209		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) Solomon Gurvitz MRS. GITZ MIKHAILOVICH				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM ROITBURD			
19a. INFORMANT'S NAME (Type/Print) MRS GITA MIKHAILOVICH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2926 TANEY ROAD, APT. 2B BALTIMORE, MD 21209			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) BALTIMORE HEBREW		20c. LOCATION — City or Town, State 10-17-94 REISTERSTOWN, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D23767		29d. DATE SIGNED (Month, Day, Year) 10/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEBRA S WOLFEINER MD 2434 W. Belvedere Ave Balto MD 21215							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from the front of this permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SOLOMAN				2. DATE OF DEATH MONTH OCTOBER DAY 17 , YEAR 1994				3. TIME OF DEATH 10:14 A M							
4. SOCIAL SECURITY NUMBER 239-34-2236		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 10/3/1922		8. BIRTHPLACE (State or Foreign Country) N. Carolina			
9a. FACILITY NAME (If not institution, give street and number) 401 EAST 25TH STREET						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE						9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 401 E. 25th Street						10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown				16b. KIND OF BUSINESS/INDUSTRY Cocoa Colo Co.							
17. FATHER'S NAME (First, Middle, Last) Roscoe Derr						18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Hunter									
19a. INFORMANT'S NAME (Type/Print) Myrtle Hooper						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 E. Pine Street Lincolnton, NC 28092									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gold Hill Bapt. Ch. Cem. 10/21				20c. LOCATION — City or Town, State Lowesville, NC							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>						22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Fowler</i>						29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) OCTOBER 18, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>John M. R...</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30499

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>SUZANNE B. Donaldson</i>				2. DATE OF DEATH MONTH DAY YEAR <i>0-13-94</i> <i>OCT-13-1994</i>		3. TIME OF DEATH <i>6:38 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>579 44 1074</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>94</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-16-1900</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery Co</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery Co</i>		10c. CITY, TOWN OR LOCATION <i>Potomac</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8703 Stream View Rod</i>				10f. ZIP CODE <i>20854</i>		10g. CITIZEN OF WHAT COUNTRY? <i>Yes USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>no</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12+</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Nat'l Inst of Health</i> <i>Nat'l Catholic Welfare Conf</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Henri Boulet</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <i>John L. Donaldson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8703 StreamViewRd, Potomac, MD20854</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY <i>Statee Anatomy Board</i> <i>655W. Baltimore S, t Balto, MD21201</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>urerna</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>End Stage Renal Disease</i>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. DATE SIGNED (Month, Day, Year) <i>Oct 13 94</i>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. ...</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John ... 8212 W ... Ave Bethesda</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 19 1994</i>				32. REGISTRAR'S SIGNATURE <i>...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 30500

Item 18, g-716, 10-19-94, per F.H., dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA V. FRANCE				2. DATE OF DEATH MONTH DAY YEAR Oct 5, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 215-32-8344		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 10, 1914	
9a. FACILITY NAME (If not institution, give street and number) 2240 Route 97				9b. CITY, TOWN OR LOCATION OF DEATH Cooksville		9c. COUNTY OF DEATH Maryland	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cooksville		10c. CITY, TOWN OR LOCATION Cooksville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2240 Route 97				10f. ZIP CODE 21723		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) none		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Louis France				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah J.			
19a. INFORMANT'S NAME (Type/Print) Albert E. France				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 Route 97 Cooksville, Maryland 21723			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) France family lot		DATE 10/0		20c. LOCATION — City or Town, State Cooksville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R Bailey				22. NAME AND ADDRESS OF FACILITY Nutter funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ARTERIO SCLEROTIC HYPERTENSIVE CARDIOVASCULAR DIS. c. d. Approximate Interval Between Onset and Death a. MONTH b. YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OLD CEREBROVASCULAR ACCIDENT CHRONIC RENAL FAILURE						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Cezar A. Lopez MD				29c. LICENSE NUMBER D15405		29d. DATE SIGNED (Month, Day, Year) OCT 13, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEZAR A. LOPEZ MD 18111 PRINCE Philip Dr - OLNEY MD							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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